0326

VOLUME II

IN THE UNITED STATES DISTRICT COURT

FOR THE SOUTHERN DISTRICT OF OHIO

WESTERN DIVISION

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J.B.D.L. CORP. d/b/a BECKETT APOTHECARY, et al. : CIVIL ACTION

vs. :

WYETH-AYERST LABORATORIES, INC., et al. : NO. C-1-01-704

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MAY 19, 2004

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Continued videotape deposition of DAVID J. GIBSON, M.D., taken pursuant to notice, was held at the law offices of REED SMITH LLP, 2500 One Liberty Place, 1650 Market Street, Philadelphia, Pennsylvania 19103-7301, beginning at 9:08 a.m., before McKinley Wise, a Registered Professional Reporter and an approved Reporter of the United States District Court.

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I N D E X

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GIBSON EXHIBITS

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DEPOSITION SUPPORT INDEX

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THE VIDEOGRAPHER: Good morning. Here begins Day No. 2, Videotape No. 1 in the deposition of David Gibson in the matter of J.B.D.L. versus Wyeth in the United States District Court, Southern District of Ohio.

Today's date is May 19th, 2004, and the time is 9:08 a.m. Deposition is being held at One Liberty Place, Philadelphia, Pennsylvania, the law offices of Reed Smith.

The videographer is Michael Panichelli, here on behalf of Esquire Deposition Services located at 1880 JFK Boulevard, Philadelphia, Pennsylvania.

All counsel will be noted on the stenographic record.

The court reporter is Mac Wise, and he'll now swear in the witness.

MR. DOBIE: Dr. Gibson, you understand you're still under oath?

DR. GIBSON: I do.

MR. DOBIE: All right. Why don't we just get started then, Mac, if that's okay

with you.

THE COURT REPORTER: I'm fine.

MR. DOBIE: All right?

* * *

DAVID J. GIBSON, M.D., resumed.

* * *

BY MR. DOBIE:

Q. Let me just follow up, Dr. Gibson, on some -- some things that you said yesterday.

A few times yesterday you mentioned that, quote, we haven't received certain documents and data. Now, you do understand that counsel for the plaintiffs in this case have all the documents?

A. I'm not aware of what they have or not. I -- if you say that's the case, that -- I -- that's I'm sure true. I don't --

Q. You have no reason to dispute that?

A. I have no reason to dispute it.

Q. All right. And so when you say "we haven't received," you're saying that you haven't received certain documents from your counsel, Mr. Cohen, and the other lawyers that are working on this case; correct?

A. Correct.

Q. Now, another followup thing I wanted to ask you about it.

At PCN, sir, is it true that the health plans that contract with PCN have -- are provided with documents that -- that indicate the amount of money that they spend on pharmaceutical benefits every year?

A. Yes.

Q. And do you also provide -- does PCN also provide to health plans information concerning the amount of money that PCN is charging in administrative fees in the year?

A. Yes.

Q. And so aren't these health plans in a position then to compare PBMs in terms of cost and the cost of pharmacy benefit?

MR. COHEN: Object to the form.

A. That is an interesting question. It -- you can't get from the start of the question to the end with a yes answer. Speaking from the industry perspective, which PCN is part of, a client can calculate what their pharmacy benefit costs. A client can calculate what the rebate

amounts that came back to them were. And they can calculate what the administrative fees are.

What they will have difficulty doing is calculating if a drug was substituted or encouraged to reward a rebate structure. In other words, a more expensive drug would be encouraged for use because it profited the PBM on their rebate contracts.

BY MR. DOBIE:

Q. All right. But if they have the amount of -- if they're provided -- the example that you're familiar with, PCN, if they're employed with the total pharmacy benefit costs that the plan is incurring in any given year for, let's say, the teamsters union, that's the plan, and they're told, Here's the pharmacy benefit cost that we spent last year, they know the administrative cost that's being charged by PCN, they know the amount of rebates that they have received back, they're in a position to then go to other PBMs and compare what the other PBM may be able to offer them in terms of rebates, in terms of administrative cost; correct?

A. Correct.

MR. COHEN: Object to the form.
BY MR. DOBIE:
Q. And -- and they're also in a position to evaluate whether or not they would prefer to take a larger up-front payment from the PBM versus whether to simply true-up at the end of the year; correct?
MR. COHEN: Object to the form.
A. This is a complex issue. The short answer is yes.
BY MR. DOBIE:
Q. All right. And you say that PBMs sometimes push higher price products, but then again at the end of the year the plan would see to the extent that their pharmaceutical costs had gone up; isn't that also true?
A. They would know their pharmaceutical costs went up. They wouldn't know the percentage of the increase based on certain selective substitutions.
Q. You do provide them, I assume, cost per therapeutic class, don't you?
A. You -- you provide them with -- you provide them with the amount that the contract

called for paying for a given drug.
Q. So -- so that the plan at the end of a year has from PCN not only here's the total amount of spend, but they know how much they spent on particular products; right?
A. They do.
Q. Another question I wanted to follow up on at PCN. You talked about P&T committee minutes for Omni. Are there P&T committee minutes for PCN?
A. Yes.
Q. And who keeps the P&T committee minutes?
A. It would --
MR. COHEN: You mean who -- who is the custodian or who actually writes the minutes?
BY MR. DOBIE:
Q. Let's start with who writes them.
A. I believe the -- we've had some changeover in staff. So I believe the person who writes them is a person by the name of Cathy Maskita, who is one of the consulting pharmacists at PCN.

Q. And do you receive and approve the minutes before they're -- let me back up.
What's -- what's the process for keeping minutes?
A. The minutes are kept during the P&T committee and then they are distributed at the next meeting for approval.
Q. And so the P&T committee minutes that -- that exist for PCN are all minutes that have been approved by you?
A. By me and the committee, correct.
Q. And one final followup from yesterday on FPI.
You mentioned Mr. Cates. Does he hold any position with -- with FPI?
A. He currently is chairman of the board.
Q. He is the chairman of the board of FPI?
A. Correct.
Q. And what is -- do you have a -- do you have a position on the board of directors at FPI?
A. I am the chief executive officer of

FPI.
Q. So the answer is no, you don't have a position --
A. I have --
q. -- on the board?
A. I have a position on the board and I'm chief executive officer.
Q. Who are the other board members of FPI?
A. Ed O'Donnell, the FPI -- the FBI agent -- or former FBI agent that I referenced; Carlo Michelotti, who is the CEO of the California Pharmacists Association. And there are two other individuals from California state government. I will give you the names if you'd like. I don't have those on the top of my head.
Q. And are any of these individuals paid in connection with their position on the board?
A. No.
Q. In addition to you serving as CEO, does the company have any other officers?
A. No.
Q. Does the company have any other

employees?
A. No.
Q. Does the company have any revenues?
A. Yes.
Q. And is that in connection with the contract with United Pharmacists Network?
A. Correct.
Q. And what were the revenues last year for FPI?
A. Zero last year. This year, we have a contract that is an annual of around 30,000 paid quarterly.
Q. And the --
A. So our first quarter payment is one-fourth of that.
Q. The revenues that you mentioned before from -- from FPI -- you said it's a nonprofit corporation -- would those moneys be distributed in some ways to any shareholders or is it simply to go to the expenses, which I assume --
A. Correct.
Q. -- would be your salary?
A. Well, at some point, I may take a salary, but the intent is to eventually have a

staff that is paid that will do the operational activities of the -- of the institute. The overall intent is to tell the public that fighting fraud and health care is the purview of the providers, not the buyers. So that fees charged to pay for operational costs would come from those vendors doing business in health care, not the people who come into health care to purchase.
Q. And the vendors being in this instance doctors, pharmacists?
A. It would be hospitals, doctors, pharmacists, pharmacies, durable goods companies.
Q. And you want to charge them in essence for placing the group that's the provider as opposed to charging the patient?
A. We will -- the business model calls for charging them an annual fee that is fairly small.
Q. "Them" being?
A. The vendors that -- we just went through the list. Charging them a fairly small annual fee to be a member of the panel. The fee will be about $300 each year. If we find evidence or if we find indicators that -- that raise red

flags that there could be fraudulent activity occurring within that vendor's business practices, then the fees go up for that vendor to monitor their activities, and it could go as far as our having an investigator involved on a daily basis with them.
Q. I want to change topics and kind of move on away from yesterday and cover some new things and talk about pharmacy benefit managers.
In a portion of your report which is on Page 22, you have a heading here that says "PBMs" -- "PBM failure to perform as a fiduciary for the client."
Do you remember preparing that?
A. I do.
Q. And what do you mean that PBMs have failed to perform as a fiduciary for the client?
A. I'll answer that, and let me put the context. This is a hot topic within the industry right now. There's been an effort over the past several years for the industry to have PBMs classify themselves as being in a fiduciary relationship and they have consistently declined to do so.

A fiduciary relationship takes the interest of the client as primary and the entity, in this case a PBM, would -- would conduct its business in all instances to benefit the client first. By not being in a fiduciary position, the PBM is selling services and products to its client on a competitive basis against other PBMs, but not necessarily keeping the client's best interest in mind as they run their operating organization.
Q. So is it your view that -- that PBMs should act as fiduciaries to the client?
A. I think that PBMs -- yes. The short answer is they should do that. If they don't, the backup position is they need to be completely transparent --
Q. And -- and when you say that --
A. -- in a business model.
Q. When you say that they should, are you saying that it's your understanding that -- that PBMs, in fact, are somehow required to act as fiduciaries?
A. Not by law, no.
Q. In practice, is -- it's your view that they should act as fiduciaries for clients?

A. I think it would be -- I think it would be a more trustworthy business environment if they did.

Q. Is that the -- is that the standard in the industry currently that PBMs act as fiduciaries for their clients?

A. It's the standard in the industry that they do not.

Q. Does PCN act as a fiduciary for their clients?

A. PCN is not a fiduciary for the client.

Q. In fact, PBMs and the client, if it's a teamster plan, are basically across from each other at the table rather than sitting on the same side, aren't they?

A. They're two businesses doing business with each other through a contractual bridge.

Q. And they are not -- PBMs are not fiduciaries?

A. Correct. And that -- that was the reason for this heading. That's the context for this.

Q. But it's -- just so I understand this, it's your view that the rule should be that PBMs should act as fuduciaries for, to use your example yesterday, the teamsters union plan?

A. Yes. And the reason is this is such a convoluted business. There's so many nooks and crannies to hide money in that's easy to take advantage of the client.

Q. All right. And -- and have you expressed your view to the management of PCN that it should act as a fudiciary for all of its clients?

A. I've consistently taken that position with PCN and throughout the industry.

Q. And -- and what's been the reaction by your employer to your -- your view that PCN should act as a fiduciary?

A. I think PCN's position is that they don't -- they -- they have the most transparent business model -- or business -- they are the most transparent of any P -- of the PBMs in the industry or among the most transparent and they don't have all of the other places to hide money, particularly in the mail order.

Q. Is it your view that the PBMs should disclose their -- let's say the profits they make on -- on contracts to health plans?

A. It is my opinion that they should do one of two things. They either should bind themselves to their clients as fiduciaries or they should be completely transparent.

Q. And by being completely transparent, what do you mean?

A. That is they disclose all their sources of revenues and they disclose all their -- all their sources of expenses to their clients.

Q. And by all sources of revenues, you would have PBMs disclose all the rebate dollars that they receive from the manufacturers and all other revenue sources to each of its client in connection with -- with --

A. For their account.

Q. For their account. And is that opinion of yours -- is that -- is that a basis for your conclusions in this case? You have this in your report. I assume it is.

A. I would -- I would say that it's part of my structure of my opinions.

Q. All right. But by the same token, you'd agree that that isn't the rule today, that there is no PBM that takes the view that they should either bind itself as a fiduciary or be completely transparent and disclose all sources of revenues to its plan members?

MR. COHEN: Object to the word "rule."

A. There's a very great effort in the industry now to proclaim to the clients that they're transparent.

BY MR. DOBIE:

Q. But in terms of the practice that's followed by the PBMs, including PCN -- let's start with the first -- the first example.

Are you aware of any PBM that accepts your view that they should -- that they should be a fiduciary for the client plans?

MR. COHEN: Object to the form.

A. No.

BY MR. DOBIE:

Q. All right. And are you aware of any plan that -- or any PBM that currently is completely transparent and discloses all sources

of revenues to each client plan?
A. I know that almost every top-tier PBM in the industry is now telling their clients that they are transparent.
Q. And how do you know that, sir?
A. Because I've been at the meetings where they say that.
Q. All right. And if that's -- so currently then PBMs are, in fact, disclosing to the client plans all of the information concerning their sources of revenue for each and every one of their contracts; right?
MR. COHEN: Object to the form.
That's not his testimony.
A. That's not what I'm saying. I'm saying that's what they are telling their clients they're doing. I'm not -- I'm not testifying to the fact that they're doing that.
BY MR. DOBIE:
Q. Okay. Well, if -- would you agree with me that if they're telling their clients that they're doing that and then the client goes in and negotiates a contract with a PBM and the -- and the PBM in turn doesn't do what they said that

if they don't do what the monopolist wants. So that's perhaps a nuance to what -- to the definition. I'm not sure.
Q. Is that because of a concentration of market share?
A. Correct.
Q. And do you have any understanding of when it is and when it is not appropriate to be a monopolist?
A. I have a general knowledge --
Q. All right. Tell --
A. -- but I'm not a legal expert, no.
Q. Are you applying your definition of "monopoly" in connection with the report that you've --
A. Yes --
Q. -- issued?
A. -- that's -- what I just mentioned to you is how I use that term.
Q. And it's your intention to -- to express to the jury this view of monopoly that you've just explained?
A. Correct.
MR. COHEN: Object to the form.

they would do, that the -- that the client plan might decide to do business with someone else?
MR. COHEN: Object to the form.
A. I would agree with that, yes.
BY MR. DOBIE:
Q. Okay. You also use in -- in your report the term "monopoly" on various occasions.
How do you define a monopoly? Are you a -- do you hold yourself out as a legal expert?
A. No, I don't.
Q. Okay. So how do you use and why do you use the term "monopoly" in your report?
A. I use the term "monopoly" in the context of a company dominating a class of drugs and being able to impose its will on the market in a noncompetitive fashion.
Q. Do you have any other definition of "monopoly" as you use it?
A. I think a nuance of it would be that if you're competing in -- if you have competitors in a market, they generally compete for business based on add-ons or benefits to the customer. A monopolist can put in place damage to a customer

BY MR. DOBIE:
Q. Do you have any other definition or -- or view of what a monopoly is other than what you've told us so far?
A. I can't think of it now. I suppose in conversation if something comes up, I will add to it and -- but as of now I've tried to give you in a responsive way what I generally view as a monopoly.
* * *
(Whereupon, Gibson Exhibit 15 was marked for identification.)
* * *
BY MR. DOBIE:
Q. Okay. For the record, Exhibit 15 is a copy of another document prepared for the California Health Care Foundation from Mercer Human Resources Consulting. Sir, have you seen this document before?
A. Okay. The Exhibit 12 was the same date but it was a different title. So this is a different --
Q. Different report?
A. Let's see. I get daily updates from

the California Health Care Foundation on all of their publications and their newsletter.

MR. DOBIE: Let's go off the record for a second.

THE VIDEOGRAPHER: Going off the record. The time is 9:31 a.m.

* * *

(Whereupon, a discussion was held off the record.)

* * *

THE VIDEOGRAPHER: We're back on the record. The time is 9:31 a.m.

BY MR. DOBIE:

Q. Let me ask you to draw your attention to Page 22 of Exhibit 15.

A. Okay.

Q. Okay. There's a statement on Page 22 as a description of wholesalers in the industry and it notes that the top five wholesalers of pharmaceuticals now account for approximately 90 percent of the entire wholesale drug market."

Were you aware of that, sir?

A. Yes.

Q. So are you aware that these five

large wholesalers are very big companies?

A. Yes.

Q. And very sophisticated companies?

A. Yes.

Q. And -- and would you say that these companies have significant power in the marketplace as it relates to pharmaceuticals and -- and what they pay for pharmaceuticals?

MR. COHEN: Object to the form.

A. I don't -- I don't think that there's any particular selective power that any of them have.

BY MR. DOBIE:

Q. Is there -- do you have ever have any concerns or have you ever had any concerns that these five wholesalers have a concentration of the -- of the market for the purchase of pharmaceutical products?

A. I have a concern any time any segment of the market concentrates, but it's the nature of markets to do that.

Q. All right. And have you had any discussions with anyone about this large concentration of market share as it relates to the

wholesalers for pharmaceutical products?

A. Not that I recall other than perhaps chitchat with people, but no.

Q. In your report, you don't discuss the fact that these top five wholesalers now account for 90 percent of the wholesale drug market, do you?

A. I don't believe I do.

Q. And why not?

A. Because I didn't view it as being a major issue.

Q. All right. Let me ask you to turn your attention to Page -- Page 18. Page 18 and then if you look over on Page 19 have a picture in essence of how the pharmaceutical money flows if an employer plan either decides to keep the pharmacy benefit carved in -- in other words, they're going to pay for that -- and Page 19 has the flow of pharmaceutical money when the PBM benefit is carved out. Look at that.

A. Okay.

Q. And is there -- is there anything in this chart that appears inaccurate to you, either the chart on Page 18 or Page 19?

A. Okay. If you'll give me a minute --

Q. Yes, sir.

A. -- I'll look at these and then answer your question.

Okay. I've finished looking at the chart on 18, and that looks pretty much the way the industry is structured for a carve-in and consistent with the chart that I gave you in my report --

Q. Yes, sir.

A. -- at the top. And on Page 19 -- on Page 19, you have the same -- basically the same structure except you remove the left-hand side where we have the medical administrator that had the PBM under contract. So yes, I -- the short answer is yes.

Q. These -- these appear accurate?

A. Yes.

Q. Okay. Now, on your report -- in your report, I'm sorry, on Page 17, you state that there are approximately a hundred PBMs in the U.S. but that the top four companies dominate the industry. And you don't have --

A. I'm sorry. What page are we on now?

Q. Page 17.
A. Okay.
Q. You note in the -- under "The PBM role in the distribution process," second paragraph --
A. Okay.
Q. -- last sentence, you say there are approximately a hundred PBMs in the U.S., but the top four dominate the industry. There's no cite there. Do you know where you got that information?
A. I believe it came from the same sources that I had cited earlier wherein -- let's see. It wasn't earlier. It was -- it was on Page 24 I cite the number of lives covered by company and indicate that there's a first tier which are companies that cover over 20 million lives.
Q. Where did you get the information that there's, I'm sorry, approximately a hundred PBMs in the U.S.?
A. I don't recall exactly where I got that. It could have been from here, but I'm not sure.
Q. But again, is this data that you

have not verified in any way?
A. It's data that I've picked up through my reading of research, but I didn't happen to footnote that particular point.
Q. All right. The reason I ask, sir, is if you turn to Page 25--
A. Of my report?
Q. Yes, sir.
A. Okay.
Q. Now, here you say that there are 50 companies classified as PBMs. You see that?
A. Uh-huh.
Q. Which one is it? Are there 50 PBMs or are there a hundred?
A. Let's see. I'd have to pull my data to give you the correct answer on that. It could be both. And let me explain.
The 50 PBMs would be those that are clearly classified as PBMs. There are a number of carve -- again, the word "carveout" comes out. There's a number of carveout PBM-like entities that will use companies like Argus in Kansas City to administer the benefit and they will do their direct contracting. This, interestingly enough,

is becoming much more common in the industry. So that states now are carving up the pharmacy benefit and using specialty subcontractors like Argus and then renting -- renting networks for the pharmaceutical retailers and setting their own contracts with the mail orders.
So the delta, or the difference, between the figure on Page 25 and the figure on Page -- 18, was it?
Q. 17.
A. 17. There's -- that's part of that gray area as to how you define what is or isn't a PBM. So I could -- I think with a little work I could give you the -- to square the circle on those two numbers.
Q. But have you squared the circle? Have you looked at this to figure out which -- which of the -- let me finish the question -- which of the -- which of the two numbers is right, whether it's 50 or a hundred PBMs?
A. The right number for the graph on Page 25 and on 24 is the 50. The right number on the hundred I believe is also correct, but I don't have that research for you.

Q. All right. And -- and you think that -- that the other 50 PBMs are in essence claims administrators?
A. No. Well --
Q. Like Argus?
A. I think that they are PBM arrangements where the client plays a much more prominent role. For -- a clear example of that would be the Blue Cross -- Blue Shield of California product that we discussed yesterday wherein they subcontract with Argus and inhouse they administer their own rebates and they manage their own networks.
Q. Okay. And so if -- if we go to the data on the hundred, it's your testimony that -- that what we're going to see is that those are what the other 50 PBMs are and --
A. That would be my -- that would be what I would think is in there.
Q. All right. Do you know?
A. I don't.
Q. In your -- let me ask you kind of generally. If we step back for a moment, in your experience, isn't it possible that even if a

particular PBM has a plan that is classified as general -- generally speaking as open or incentive-based or closed, that with respect to particular drug products, it can make an exception and allow a drug product to be made available at the same copay to its members even if that would not normally qualify under its plan?

MR. COHEN: Object to the form.

A. You can ask the most complex questions.

I think what I'm hearing, and tell me if I'm responding to the wrong question, are you telling me -- asking me whether or not a benefit plan adminstered by a PBM can make a drug available on any given tier irrespective of its formulary status? Am I -- is that the question?

BY MR. DOBIE:

Q. Yes, why don't you answer that.

A. Okay. The answer is yes, you can override anything within the formulary structure with a prior authorization.

Q. Okay. In connection with prior authorization, are you familiar, though, sir, with situations where PBMs without a prior

authorization have made any -- strike that.

Are you aware of whether or not a PBM can simply make the decision that regardless of whether the product is listed as a -- whether or not the plan is designed as an open plan, a closed, or a three-tier, it can actually decide to reimburse a particular product as -- and treat it at the same copay as any product that, let's say, is on formulary without prior authorization?

A. I don't know of instances for that, but I wouldn't be surprised. Let me just say they have to be very careful here, because if they -- if they -- if they do not administer the plan uniformly across the beneficiary pool, they will be in violation of federal law.

Q. All right. Let's -- let's assume that they do uniformly administer the plan across the benefit pool such that a particular product is, in fact, reimbursed at the -- a branded product is reimbursed at -- in the -- like any other branded product, irrespective of it being on formulary or not, are you familiar with that happening in the -- in the industry?

A. I'm not familiar, but I -- like you

say, I wouldn't necessarily be surprised.

Q. In the course of reaching your opinions in this case, did you examine the extent to which that actually occurred in the marketplace with respect to Cenestin?

A. No, I did not.

Q. In your last deposition, you were shown some data that had to do with the extent to which various plans were, in fact, reimbursing Cenestin and -- through basically an open formulary system the same as in a -- as in a branded -- strike that.

Have you, sir, made any investigation in -- in terms of to what extent Cenestin was reimbursed exactly the same way as Premarin in the -- by PBMs and HMOs?

MR. COHEN: Object to the form.

A. Other than researching the Wyeth's internal documents that were part of my report and footnoted, no.

BY MR. DOBIE:

Q. Here's what I'm -- okay. And so if we look at --

* * *

(Whereupon, Gibson Exhibit 16 was marked for identification.)

* * *

BY MR. DOBIE:

Q. Let me show you what's been marked as Exhibit 16. For the record, Exhibit 16 is a copy of a document produced by Duramed in this case that has a listing of HMO formulary breakdown, PBM formulary breakdown, and the number of lives broken down at a percent open, percent three tier, percent closed.

In turning to the very last page of Exhibit 16, sir, it shows that 62 percent of PBM lives as it relates to Cenestin fall within an open formulary system. You see that?

A. I see that.

Q. Have you made any investigation to determine whether that, in fact, is -- is accurate?

A. Yes.

Q. Okay. And what investigation have you made?

A. I did a -- give me a minute here and I'll -- on Page 70 of my report and 71, you will

see a breakout of most of the same companies that are listed on this chart as to the number of lives involved and Wyeth's contractual status either as an exclusive conjugated estrogen or as a preferred product, which is almost universal across the board.

Q. Okay.

A. So I think that's -- that would be my research.

Q. All right. Did you do anything else?

A. I looked at a number of documents which you've seen --

Q. The Wyeth documents?

A. -- but they -- Wyeth and others. This was the most on point on the -- on the issues that I was raising and discussing in my report.

Q. Okay. So -- so what you have here on Page 70 running over to 71 is a breakdown of the Wyeth contract and whether they have a sole conjugated estrogen-language contract, a preferred oral estrogen contract, this is what you're relying upon --

A. I am.

Q. -- principally?

A. Well, that's -- that's one of the major things, yes.

Q. Okay. What I'm -- what I'm suggesting to you is something different, okay, and it's this: Regardless of whether or not any of these particular plans, let's say PCS, had an agreement that Wyeth would be a -- in this instance, a preferred oral estrogen, you understand that PCS, if it has an open plan, could still reimburse Cenestin at the same copay level as Premarin; correct?

MR. COHEN: Object to the form. Lack of foundation.

A. I would disagree with that.

BY MR. DOBIE:

Q. Okay. Did you read Mr. Finneran's deposition or Mr. Carter's deposition in this case, the individuals that were involved with preparing Exhibit 16?

A. No.

Q. Do you know what effort they made to examine the -- and put together Exhibit 16 so that it would break down the amount of lives that were,

in fact, open for Cenestin?

A. I didn't read the deposition and I don't know the methodology. The key here is definitions. What does "open" mean?

Q. Okay. And if Mr. Finneran testified that by -- by preparing this document, they intended to mean reimburse at the same copay with no prior authorization, don't you think that this would be relevant, having an understanding of what -- of whether or not that is, in fact, the case in reaching your conclusions?

MR. COHEN: Object to the form.

A. I'd be highly skeptical of that interpretation of this report.

BY MR. DOBIE:

Q. Okay. Have you done any investigation to get behind this and figure out whether or not that, in fact, is what the situation was at -- at these companies as it relates to Cenestin?

A. I think Wyeth's own internal documents that I've put into my report rebut this rather effectively.

Q. Don't you think that Duramed would

be the company that would be in the best position to know what its formulary status was for its own product?

MR. COHEN: Object to the form.

A. What this report says is they are reporting their lives -- their -- they having access to their lives in an open status. That does not say that it's preferred or not positioning on the market. It doesn't say anything about what copayment structures are.

BY MR. DOBIE:

Q. Okay. But again, if the testimony of the witnesses is undisputed and they've admitted that by preparing this document they meant the same copayment, that's what they mean by "open," with no prior authorization involved, how have you -- how have you incorporated this into reaching your conclusions, if at all?

MR. COHEN: Object to the form.

A. I read many things that I'm -- if I'm skeptical or don't agree with it would not include it. I did not read the deposition and I would be highly surprised if they say that their drug, in light of what you have here on my Page 70

and 71, are on an equal financial positioning with Premarin in all of these companies.
BY MR. DOBIE:
Q. All right. I understand you'd be surprised, but if, in fact, that is what the facts demonstrate, does that change your opinion at all?
MR. COHEN: Object to the form.
A. I would just have to look at it to give you an answer on that. I'm not prepared to take your hypothetical and tell me that I would -- and answer that I would change my opinion.
BY MR. DOBIE:
Q. All right. You haven't looked at Exhibit 16 before, have you?
A. Have I looked at it?
Q. Have you looked at Exhibit 16 as part of the preparation of your report?
A. No.
* * *
(Whereupon, Gibson Exhibit 17 was marked for identification.)
* * *
BY MR. DOBIE:
Q. Let me show you another document.

Let me show you what's been marked as Exhibit 17.
For the record, Exhibit 17 is a copy of a managed care overview 2001 business plan dated October 27, 2000, cover memo from Mr. Marty Carter to Jeff Arington.
Sir, do you know who Marty Carter is?
A. No, I don't.
Q. Do you know who Jeff Arington is?
A. No.
Q. Okay.
A. Well, it's listed here who Marty Carter is at the bottom of the page, but I -- personally I didn't know until I read this.
Q. Have you ever seen this document before?
A. I don't recall having seen it.
Q. All right. This is -- as it indicates here, Marty Carter is the executive director of managed care at Duramed Pharmaceuticals. Jeff Arington was the president of Duramed Pharmaceuticals. And if -- if you turn to the second page of Exhibit 16, it notes in the very first bullet point, "Cenestin continues to

have access to a minimum of 75 percent of the managed care lives." Do you see that?
A. I do.
Q. And again, did you in any way incorporate this into your report or the conclusions that you've reached?
A. It -- having access to the lives on the third tier is for the -- for the most part irrelevant.
Q. All right. And is that because in your view the -- well, let me -- let's back up.
Do you know whether or not this is access on the third tier or if this is access not on the third tier?
A. I know based on the table that I cited from Wyeth that it is -- it is likely that all of this is third-tier access.
Q. Okay. If you look at Exhibit 15, sir, which is also a memo from Mr. Carter, executive --
A. 15?
Q. Yes, sir. I'm sorry, 16. The executive director of managed care for -- for Duramed?

A. Uh-huh.
Q. It doesn't say 75 percent is third tier. He says 62 percent is open. 30 percent is three tier. Do you see that? So this is November of 2000.
A. All right. You're referring to Page 1 through Page --
Q. I'm referring to the last page of Exhibit 16, the same page --
A. The last page? Okay.
Q. Yes, sir. And on the PBM side, he's got 62 percent open, 30 percent third tier. Do you see that?
A. I see that.
Q. Okay. So in light of that, do you think it's reasonable to assume that Mr. Carter is referring to 75 percent of the managed care lives having access to as being third tier?
MR. COHEN: Object to the form.
A. I'm -- I'm not sure from this chart how he is defining that. He lists that Cenestin was available in only 8 percent of the closed lives.
BY MR. DOBIE:

Q. Right.
A. He indicates that on the third tier they were available for 30 percent.
Q. Correct.
A. I don't know exactly what the definition of "open lives" here on this chart is.
Q. 62 percent.
A. I know what the numbers are listed.
Q. All right. But go back to my question.
A. It would be helpful if he had a footnote.
Q. My question was, why do you believe in light of Exhibit 16 that by him stating in the business plan for Cenestin for 2001 that Cenestin continues to have an access to a minimum of 75 percent of managed care lives and Mr. Carter was referring to third tier when his own document from the same time period says 30 percent third tier and 62 percent open lives within the PBM formulary system?
MR. COHEN: Object to the form.
A. I can't square the circle on that.
BY MR. DOBIE:

Q. And again, you haven't -- you haven't considered Exhibit 16 in reaching your conclusions here?
A. Correct.
* * *
(Whereupon, Gibson Exhibit 18 was marked for identification.)
* * *
BY MR. DOBIE:
Q. Let me show you -- sir, I've handed you Exhibit 17. Have you ever seen this document before?
MR. COHEN: Did you say 18?
MR. DOBIE: Oh, 18.
A. Not that I recall.
BY MR. DOBIE:
Q. Okay. This -- this is a document that again comes from Duramed and it's from John Neeley, who is -- who is one of the managed care people hired by Duramed that work for -- for Viking for the executive director of managed care for Duramed, Marty Carter.
Sir, you note in your report that there are four significant PBMs; right?

A. Correct.
Q. And the four PBMs are AdvancePCS, Merck-Medco, Express Scripts and Caremark; right?
A. Correct.
Q. And in the prior documents we were looking at, in particular Exhibit 16, this chart shows that AdvancePCS, 75 percent of lives were open; at Caremark, 75 percent of the lives were in open, 25 percent third tier, no closed formulary; Express Scripts, 40 percent open, 50 percent in the third tier, 10 percent closed; and in Merck-Medco, 50 percent open, 30 -- 35 percent in the third tier, and 15 percent in a closed formulary. Do you see that?
A. I do.
Q. And -- and again, the conclusions that you reached in the -- in your report are that contrary to this document and the statement that 75 percent -- I'm sorry. Strike that.
The conclusions that you reached in the report are basically that that's not true, right, that 75 percent -- or that these -- at least at these big PBMs the Cenestin was in the third tier in the majority of instances or in --

disadvantaged by being in basically a closed formulary; right?
A. No, that's not what I'm saying. What I'm saying is I don't know the definition of "open lives" here. That it -- in general, it's irrelevant if -- there is access to a drug if it is not on the preferred list; that once you fall off the preferred list, and the documents I cite within Wyeth attest to this, that the penalties are enormous. The patients and physicians do not know that they have access to the drug because it's not published on any formulary and all of the inhibitors, both hard edits, soft edits, and copayment structures, which are accepted throughout the industry as being very effective in moving market share, can be arraigned against a product that is some -- that is listed here as an open product.
Q. Okay. Well, we'll come back and talk about each of those and the extent to which they were, in fact, applied against Cenestin. All right.
But what I'm saying is, sir, as it relates to -- to this, okay, to these -- these

documents that we're looking at, it's true, is it not, that you've have decided in your report to use Wyeth documents principally for an understanding as to whether or not the situation with Cenestin was that it was disadvantaged as opposed to looking at Duramed's documents with its understanding of the marketplace?

A. That would be correct.

Q. Okay. And did you know, for example, looking at Exhibit 18, that -- go to the second page and look at --

A. The second page of the document?

Q. You're on the second page right there, yes, sir, Bates No. DUR10671.

Were you aware, for example, that at PCS Health Systems Duramed learned that Cenestin will be available at the same copay level as products accepted for inclusion in the 2000 formulary plan programs in at least 90 percent of their book of business or over 45 million lives?

MR. COHEN: So you're -- you're -- Gordon, you're asking him whether he learned what -- what this document says?

THE WITNESS: Was he aware of that.

MR. COHEN: What the document says.

MR. DOBIE: Yes, sir.

A. I don't recall that I was --

BY MR. DOBIE:

Q. Okay.

A. -- when I prepared my report.

Q. And -- and were you aware that it was -- looking at the last sentence under "PCS Health System," were you aware that it was Viking Health Care's proposal that Duramed continue to recommend -- I'm sorry. Let me back up.

Were you aware that Viking recommended that with this coverage for Cenestin in the vast majority of PCA plans without an agreement that it's likely that Viking Health Care Solutions will continue to recommend to Duramed the strategy in the future as it provides extensive Cenestin coverage with no rebate liability? Did you know that that was their strategy?

A. Let me just review that paragraph again.

Q. Yes, sir.

A. All right. I'm reading a paragraph

in a document that I have not seen before, so let me tell you how I'm interpreting the paragraph.

Q. I'm just asking whether you were aware of what's stated here in this paragraph.

A. I was not.

Q. All right. And do you know whether or not Viking, which was the group that was advising Cenestin and meeting with managed care executives from Medco, Express Scripts and others, was actually just trying to have Cenestin approved at the same copay level without having put -- being put on formulary?

A. It looks as though that's what they were trying to do.

Q. All right. And have you looked at Aetna? The very next item there.

A. Uh-huh.

Q. It states there that -- in the second paragraph that Viking's recommendation by Aetna in regards to Cenestin is to continue to work with physicians to generate demand, keep a low profile on the contracting side, and allow the prescriptions to be filled at the same copay level as formulary products.

Were you aware that that was the situation at Aetna, sir, for Cenestin?

A. No.

Q. If you look at the next item under "United Healthcare."

THE VIDEOGRAPHER: Stand by.

* * *

(Whereupon, a discussion was held off the record.)

* * *

THE VIDEOGRAPHER: Proceed.

BY MR. DOBIE:

Q. Under "United Healthcare," sir, on the next page, the third page of the exhibit, DUR10672, the first full paragraph on that page notes that "At this time, Cenestin is considered nonformulary, however is being reimbursed in the majority of their plans at the $13 copay level."

Were you aware that that was the situation at United Healthcare?

A. No, I wasn't.

Q. Let's look at Caremark, which is one of the other big PBMs that you identified. It's the next page, DUR --

A. Did we skip Express Scripts that was --
Q. We'll come back to Express Scripts.
At Caremark, did you -- were you aware that it was Viking -- were you aware first that at Caremark most prescriptions would continue -- most prescriptions for Cenestin would continue to go through with the normal copay for a branded product?
MR. COHEN: Object to the form.
A. This paragraph pretty much sums up why I think most of this is not on point. And it states at the top of the paragraph that Caremark was unable to contract and place Cenestin on the formulary because of the contractual restrictions by Wyeth. This would be an end-run arrangement that Caremark would have made with Cenestin to give broader access. That's how I'm reading this.
BY MR. DOBIE:
Q. Sir, do you understand the role of an expert in litigation?
A. I think so.
Q. Do you -- do you think it's your role to be an advocate or are you supposed to

objectively provide the jury with your opinions?
A. I'm -- what I'm trying to do is give you a background for how I arrived at my opinions and how I would interpret this.
Q. Okay. Is there -- sir, aren't you being an advocate? Is there anywhere in this paragraph on Caremark that there says one word about whether they have a contractual restriction with Wyeth?
MR. COHEN: Object to the form.
BY MR. DOBIE:
Q. Yes or no.
A. It does not say --
Q. Okay.
A. -- the word "contract."
Q. And when you answer my questions, you created that; correct?
A. I interpreted Wyeth's proposal --
Q. Okay. Do you --
A. -- as meaning that.
Q. And do you know whether or not Caremark even had a contract with Wyeth prior to this time period?
A. I don't know in the instance of

Caremark. I do know what Wyeth's contracts look like.
Q. Okay. And so what you are doing here in testifying is you're being an advocate and you're actually creating language in a document that doesn't exist; isn't that right?
MR. COHEN: Object to the form. Argumentative.
A. I substituted the word "contract" for "proposal."
BY MR. DOBIE:
Q. Okay. And you also substituted the idea that Wyeth had a restrictive contract with Caremark at that time, even though it's not in the paragraph; correct?
A. Even though it's not in the paragraph, with the prior knowledge of how Wyeth contracted.
Q. Okay. And you substituted that without even knowing whether or not Caremark, in fact, had a contract; correct?
A. Wrong. I know that there was a contract.
Q. Look at your --

A. Again, it's on Page 70.
Q. Okay. And look at your chart, sir. What does it say in terms of contract status for Caremark?
MR. COHEN: Where are you, Gordon?
BY MR. DOBIE:
Q. On your report -- now you're looking at your report; right?
A. Correct.
Q. Okay. And in your report for contract status, what does it say about Caremark?
A. "Not applicable."
Q. Okay. And so knowing that, knowing that Caremark didn't have a contract with Wyeth, you are now creating and adding language to a document in order to be an advocate for your clients; isn't that right?
MR. COHEN: Object to the form.
A. I'm -- I'm interpreting a document you're giving me for the first time based on my knowledge of what the contracts are.
BY MR. DOBIE:
Q. Okay. Your knowledge and your report is that they didn't have a contract with

Caremark and yet you answer the question by assuming that there was; correct?

MR. COHEN: Object to the form.

A. Correct.

BY MR. DOBIE:

Q. Okay. All right. Can you be an objective expert here today, sir?

MR. COHEN: Object to the form.

A. I am and I can be.

BY MR. DOBIE:

Q. Okay. Can you answer my questions as opposed -- as opposed to creating language in documents that doesn't exist?

MR. COHEN: Object to the form.

A. I'd be happy to.

BY MR. DOBIE:

Q. Okay. Let's try that.

Have you -- have you ever acted as an expert before in any case, sir?

A. You and I both were involved in my prior experience as an expert.

Q. Has any judge ever certified you as an expert in any case?

A. I don't know whether that occurred

A. I see that.

Q. Okay. And were you aware that at Caremark most Cenestin scripts would continue to go through with the normal copay?

MR. COHEN: Are you asking him is he aware of what this document states or separate and apart from this document?

MR. DOBIE: Was he aware of that at the time that he prepared his report.

THE WITNESS: No.

BY MR. DOBIE:

Q. Do you have any reason to know that that's not true?

A. No.

Q. And where it says here that -- were you aware of the next sentence under "Caremark," that "While there is not clearly an opportunity to contract for formulary inclusion, there is an opportunity to contract for access. However, I see little upside in doing so. Basically we would be paying for prescriptions that will be going through the system anyway." Do you see that?

A. Yes.

Q. Okay. And do you have any -- did

within the Duramed case or not.

Q. Do you have an understanding of what the rules are for an expert witness?

A. Generally, yes.

Q. Okay. And what's your understanding of the role of an expert?

A. That I am to give -- that I am to review a case and to give an opinion based on my experience in the industry as to what occurred and how it occurred.

Q. Okay. Do you understand you have to be objective, sir?

A. Yes.

Q. Do you understand you're not supposed to be an advocate?

A. Yes.

Q. Okay. Let's go back to Caremark.

With Caremark, sir, looking at Exhibit 18, it states that with the exception of the mail-order segment that the fact that Premarin was on formulary will have minimal impact on Cenestin prescriptions. Most prescriptions would continue to go through with the normal copay. Do you see that?

you have any understanding of that at the time that you wrote your report?

A. No.

Q. And -- and sir, don't you think it's relevant to your report if -- so far we've covered the three biggest PBMs -- if, in fact, it was true that Cenestin prescriptions were going through with the same copay as Premarin?

A. I think it's relevant.

Q. Okay. And how is it relevant?

A. It would mean that a -- that at the point of dispensing it would not generate a callback.

Q. All right.

A. Or a problem for the patient as far as what they were paying out of pocket.

Q. All right. And to that -- to the extent that this is true, that Cenestin prescriptions went through at the same copay level without a prior authorization, without an NDC block or anything like that, would that impact in your expert opinion the extent to which Cenestin was, in fact, disadvantaged in the marketplace?

A. It would be a factor.

Q. All right. And have you investigated whether, in fact, this is true, that there -- that Cenestin prescriptions were reimbursed at the same copay level as Premarin, as indicated in Duramed's documents?
A. The --
MR. COHEN: With respect to Caremark?
MR. DOBIE: At all.
A. At all?
BY MR. DOBIE:
Q. Yes, sir.
A. The research which is cited in my report starting on Page 78 and going to 79 are some representative examples that I pulled out of the documents that do not indicate that patients arriving at the pharmacy to get a prescription were not being disadvantaged.
Q. Okay. And those are 12 examples; correct?
A. Correct.
Q. And have you examined anything beyond this broader -- these 12 examples to see whether or not it is the case that Cenestin was,

in fact -- strike that.
Beyond these 12 examples, do you know whether or not Cenestin was reimbursed at the same copay level as Premarin, as indicated in Duramed's documents?
MR. COHEN: For -- for all plans?
MR. DOBIE: Along the lines of what's indicated in Exhibit 16, 17, and 18.
A. I pulled and cited these cases. I read a number of them. In -- in the interest of not having this thing run any longer than it did, I didn't include every document that I read. But you have a list of what I reviewed, and these were the more interesting examples of where patients were disadvantaged when Cenestin was prescribed.
BY MR. DOBIE:
Q. Okay. And of these 12, for example, you don't know whether -- whether Wyeth had an exclusive contract with respect to any of these 12, do you?
A. I have indicated in my report the examples of exclusive contracts that they had, but I'm not certain that they matched up with each of these --

Q. Okay.
A. -- correct.
Q. So as it relates to these 12, we don't know whether or not Wyeth had any contract with any of the health plans that are indicated here; correct?
A. No, that's not correct. Go back to Page 70. You made the point about Caremark, which is the only company listed here that does -- does not indicate what its contractual status is. The rest are all active accounts.
Q. You're not answering my question, sir. I'm asking about your 12 examples.
As it relates to those 12 examples where people had script turned away for Cenestin, you don't know whether or not any of these -- any of these individuals who had the Cenestin script turned away was -- had a script turned away because of a Wyeth contract; correct?
A. The performance of the dispensing pharmacist flows directly from the underlying contracts. I can infer it but I don't know it.
Q. Okay. But just take an example here. Your second one. "Physicians describe how

Florida managed care plans are rejecting Cenestin prescriptions. The physicians are frustrated." Do you see that?
A. I do.
Q. You don't know whether or not the plan had previously reviewed and rejected Cenestin because of, let's say, its limited indications, because it had just gone on the market, because it only was available in one size, .625, at the time of launch? Those are all reasons why a health plan could have rejected Cenestin for formulary inclusion irrespective of they had a Wyeth contract; right?
A. I see your point. Correct.
Q. Okay. I mean, for example, these plans, they could have had contracts with Solvey to make estradiol their -- their exclusive product; correct?
A. Correct.
Q. Now, you mentioned -- you mentioned Express Scripts as another example. Express Scripts --
A. Are we on Exhibit 18?
Q. Yes, sir.

A. Okay.
Q. Were you aware that -- that Express was -- Express Scripts reviewed and placed Cenestin on formulary in 2001?
MR. COHEN: Object to the form.
A. Yes.
BY MR. DOBIE:
Q. All right. And do you know it's on the formulary in '02?
A. Yes.
Q. And '03 and '04?
A. I am.
Q. Have you made any investigation to see whether or not Cenestin has done better at Express Scripts since it went on formulary?
A. I investigated the market performance of Aetna.
Q. Okay. Have you made an examination of the market performance of Express Scripts?
A. I don't recall that I included it in my report. I may have read about it.
Q. And -- and do you have any recollection of how it did?
A. It's my recollection that their --

their performance -- Cenestin's performance improved.
Q. Do you know whether it -- it does better than its national market share at Express Scripts; in other words, where it's on formulary?
A. I don't know that.
Q. Okay. Do you know -- have you made any examination of -- let me back up.
Do you know where else Cenestin is on formulary?
A. On formulary as defined by which position on formulary?
Q. As -- as the preferred product.
A. As the preferred product?
Q. Yes, sir.
A. And in what year?
Q. In any year. You mentioned the Aetna example. Have you made any other examination in terms of how Cenestin has done after going on formulary at any plan?
A. It is my general view and review that Cenestin has been gaining access, as have other estrogen products, to the second tier in a more advantageous way since 2001, 2002 to the

present.
Q. Okay. And -- and do you know whether or not, for example, Cenestin is on formulary now at Medco?
A. I don't know. I wouldn't be surprised that it is.
Q. Do you know whether or not it's on formulary at Humana?
A. And again, I would expect that it would be, at least third tier.
Q. Do you know whether --
A. I don't know if it's the second tier.
Q. Do you know whether it's been on formulary in the second tier since 2000?
A. I don't --
MR. COHEN: At a particular -- at Humana, you're saying?
MR. DOBIE: Humana.
A. I don't know.
BY MR. DOBIE:
Q. Have you made any investigation in terms of whether or not Cenestin has done any better at any plan where it's on formulary

compared to its national market share other than at Aetna?
A. Aetna is where I focused my attention. The reason I was focusing as I did is the majority of these -- what this case is bracketed by is a time frame in the past, not the present. So my access to what their formularies were in 1999, for instance, I didn't have that data or I didn't -- I didn't obtain that data.
Q. Okay. You didn't ask your counsel for that data; correct?
A. No.
Q. But you're not saying that your counsel didn't have that data; right? You just weren't interested in reviewing it?
A. I'm unaware of what my counsel has. I know that what my counsel -- what -- what Mr. Cohen has provided to me on my request.
Q. On Page --
THE WITNESS: Wonder if we could take a break.
MR. COHEN: Gordon, can we take a break?
MR. DOBIE: Sure.

THE VIDEOGRAPHER: Going off the record. The time is 10:25 a.m.

* * *

(Whereupon, a short recess was taken.)

* * *

THE VIDEOGRAPHER: We're back on the record. The time is 10:35 a.m.

BY MR. DOBIE:

Q. Dr. Gibson, I want to ask you about a statement on Page 14 of your report. You state -- you can find it there, but you'll probably recall -- "PBMs may or may not pass on some of the manufacturer's rebate received by" -- "received to their client, but generally do not pass on administrative fees received from manufacturers." Correct?

A. Correct.

Q. Okay. And we were talking about the pass on the rebates yesterday and I think you mentioned that you weren't aware of any authoritative sources -- we ventured your history now from PCN, but you weren't aware of any authoritative sources that indicated the amount of

pass on the rebates that usually occurs; right?

A. The only thing that I -- the only thing that I've seen that would reflect contractual relationships within companies would be the document you showed me yesterday with Merck-Medco.

Q. Okay. I'm talking about not the rebates from -- from manufacturers to the PBMs. I'm talking about the pass on the rebates from PBMs to health plans.

A. Yes. I quote in my -- in my report industry sources and -- and knowledge of what the range for rebates are between the manufacturer and the PBM, but I don't have a handle on the percentage passed back to the customer, and one of the reasons that that's a hard number to give you is it's quite a moving target.

Q. Are there -- do you believe that the rebates that may be passed on by manufacturers at up to 70 to 90 percent on average?

MR. COHEN: You said "by manufacturers."

MR. DOBIE: I'm sorry. Let me restate the question.

BY MR. DOBIE:

Q. Do you believe that -- that PBMs pass on rebates at between 70 and 90 percent on average?

A. I will tell you that the percent of rebate passed through to the customer is higher today in 2004 than it was in 1999. The reason for that is that more of the PBM's revenue is now being derived from their mail order than from their rebate. In other words, they're not as reliant upon the rebate dollar for their profit.

Q. How about in 2000; do you believe that PBMs passed on rebate dollars at between 70 and 90 percent on average to their health plans?

A. 70 percent I would think would be within a range that wouldn't be surprising. 90 in the year 2000 I would find -- I would -- I would bet would be unusual.

Q. Okay. And so we know at PCN you do that with your MediCal formularies, but -- but you think otherwise that would be true at the high end of the range?

A. I would.

Q. And do you think the low end of the

range would be about 70 percent?

A. In what year?

Q. 2000.

A. In 2000. I think the low -- and again, what clients? The different -- this is a negotiated arrangement client by client. So if you have a fairly unsophisticated client as opposed to a sophisticated client -- we can go through all how that is differentiated -- the unsophisticated client would likely get less than a sophisticated client.

Q. Okay. Do you have any sense of what the range was, though, in 2000? Would it be betweeen 70 and 90 percent? You think that's a fair range?

A. I would not be surprised that that would be the number.

Q. Okay. And, in fact, one of the documents we were just looking at, Exhibit 15 -- let me show you that. If you turn to Page 6, in the second column right before "Health Plans," the word "Health Plans," that heading, there's a sentence that notes that "The U.S. Department of Health and Human Servicess estimate that PBMs

receive direct rebates from manufacturers ranging from 2 to 35 percent of brand name drug sales prices and pass on about 70 to 90 percent of those direct rebates to insurers or self-insured employers." Do you see that?

A. I do.

Q. And then the citation is there -- I can see you thumbing to that -- that's actually a report to the president, prescription drug coverage spending, utilization, and prices from April of 2000; right?

A. Correct.

Q. And that's actually a document that you yourself have cited; correct?

A. Correct.

Q. And -- and so in light of that, sir, would you -- you don't have any reason to quarrel with the fact that -- the best -- the best estimate that was out there at least in the year 2000 of the amount of rebates being passed on is from 70 to 90 percent?

A. Yes, I'd accept that.

Q. And would you also agree that since 2000 the amount of rebates being passed on may

have gone up?

A. They may have. And I would also add that before that they were probably less.

Q. Okay. Let's talk about drug formularies, to switch topics for a moment.

On Page 31 of your report, the very top of the page, you talk about how "P&T committees generally focus upon the scientific data available concerning new drugs as they become available in the market. They're evaluated as being unique, similar to other already available products within a class of drugs or occasionally classified as unacceptable based upon risk-benefit calculations. The price of the drug and any rebate negotiations are generally not available to the committee."

Is that your experience with -- with PCN and Omni?

A. It is.

Q. And is that also your experience or understanding of how the industry generally works?

A. Generally, yes.

Q. And here's where I'm confused. You have -- other places in your report, you note

that -- that pharmaceutical products are sometimes not evaluated on the relative scientific merit. All right. And I'm just trying to sort of square the two statements.

A. Sure.

Q. Can you explain that for us?

A. I will. When the PBM committee -- or P&T committee -- we have too many acronyms here. When the P&T committee looks at drugs, as I stated in the report, it evaluates them at the end as being one of three categories. Either this is a unique drug that there's nothing else like it and it works and it should be strongly considered to be on the formulary. The second category would be similar to what is currently available. And in general, we look favorably on similar products because it broadens the drugs available on any given tier and it improves the likelihood for rebate contracts for positioning on the formulary. And we covered this yesterday on multiple drugs in class. And the third would be a drug that is -- it has just a very high toxicity, a lot of black box warnings, which is warnings by the FDA that this drug has a high likelihood of producing some

complication like liver or renal toxicity.

And it is -- if you look at overall decision making for the committee, almost all of the drugs fall into the category of similar. There's very few drugs that come out. Occasionally they come out as being unique and there are few drugs that make it through the FDA process that are just -- that lack merit, that have minimal benefits and huge risks for use.

So once the committee makes the decision and puts the drug into whichever category, it then becomes a matter for the folks that negotiate contracts to determine positioning for the products and it becomes the purview of the clients themselves and their consultants to design the benefit plan. They may elect to put a drug on a second tier that is not within the standard formulary for the PBM and they -- they will generally have a great deal of say as to what the copayment amounts are.

Q. So individual plans can elect to put their own things on formulary, have their own custom formularies, and also customize their copays?

A. Correct. Most of them don't, but some do.

Q. And -- and would you agree that -- that generally speaking that formulary inclusion should -- that the evaluation of the product should include assessing peer-reviewed medical literature?

A. Absolutely. Let me tell you what -- just to expand on that for a second.

The really important studies that we constantly ask for and rarely get are head-to-head competitive studies. In general, what we get are the placebo-controlled studies that were used to get the drug licensed by the FDA. The head-to-head studies would tell you in a live clinical blinded environment what was the clinical effectiveness of Drug A, which could be a serotonin reuptake inhibitor for depression, versus Drug B. The second type of study that we don't get and constantly ask for are economic model studies. This is particularly relevant in the case of these new expensive drugs. Your client's Enbrel would be an example in the treatment of rheumatoid arthritis.

The industry in general is asking and demanding that these expensive drugs come into the market with models showing how they affect overall spending. In other words, if you use this new drug, will it reduce complications? Will it reduce subsequent hospitalizations? Will it reduce visits to the doctor? Will it reduce tests that are needed? And what is the projected financial performance for adding this to your formulary? We get those occasionally, but it's rare, but that's -- that's something we ask for a lot.

Q. Okay. Let me follow up on the two things that you just said.

First, you do agree that it is helpful and that a P&T committee should, in fact, assess peer-reviewed literature; right?

A. Correct.

Q. And then on the head-to-head studies, let me ask you this: Did Cenestin prepare any head-to-head study that you've seen at the time that it launched this product?

A. No.

Q. All right. Do you think it would

have been helpful for Duramed to have prepared a head-to-head study when it went to the marketplace with Cenestin in terms of calling on managed care?

A. I think in this particular instance it's -- most committees wouldn't have looked for that.

Q. Do you know whether or not any committees did, in fact, look for it?

A. No.

Q. Do you know whether or not after launch Cenestin ever did a head-to-head study?

A. No.

Q. On the economic model that you mentioned, you said it is in your view helpful for a P&T committee to have information about the implications, the financial and economic implications of adding a product to formulary; correct?

A. Correct.

Q. And do you know whether or not Duramed offered such an economic study or a financial study like this to various PBMs when they -- when they called on them?

A. The short answer is no, I don't

know. The slight expansion of that is we're looking at a moving picture here.

Back in 1999, when Cenestin was coming on the market, that was not commonly requested, and in general even today, in 2004, products in the price range of Cenestin and Premarin, economic models don't really come up. It's in these new biologic agents, the injectables like anti-TNF agents, that you find the need for these economic models.

Q. Okay. And it's -- just so I'm clear, in contrast to Duramed not offering an economic model, you're aware that Wyeth did, in fact, at least arm its sales force with the economic implications of either remaining with Premarin as opposed to going with Cenestin; correct?

A. I am. And I cite it in my report.

Q. Yes, sir. And then on other things that a P&T committee should --

A. Could I stop you just a second?

Q. Yes, sir.

A. That's not the kind of economic models that we're talking about. They're the same

word but they're not the same thing.
The economic models that -- that Wyeth developed showed the consequences of adding Cenestin and what the loss of rebate dollars would be. That's not what -- that's not the economic models that P&T committees are interested in. They want to know if you use Drug A, will it reduce the incidence of hospitalization per population of some number, say a thousand lives.
Q. Well, do you know -- isn't it, in fact, the case, sir, that Wyeth does have such -- such data that indicates the efficacy of its product and -- and the extent to which use of Premarin, the extent of hospital stays -- hospital stays does, in fact, successfully treat or not treat the symptoms for which it's prescribed?
A. What year are we talking about?
Q. In '99 or 2000.
A. In '99 or 2000, the report -- the studies that they were presenting for their product were observational studies.
Q. Okay.
A. They were pre-Women's Health Initiative studies.

Q. But -- but they had such studies and Duramed did not; correct?
A. Correct. These were observational studies that had occurred over a decade of use.
Q. And in addition --
A. And most of them were proved to be wrong.
Q. Right. So that 3,000 -- are you aware that there's 3,000 clinical studies on Premarin?
A. Yes.
Q. And is it your view that most of them have been proven to be wrong?
A. If you look at the Premarin preemptive plan and the selling of science that they did which was based on those studies that were attributing reduction in the incidence of stroke, reduction in the incidence of heart disease, reduction in the incidence of cholelithiasis and gallbladder disease, and on and on, all of that was shown to be inaccurate in the definitive double blind studies that were done within the -- within the Women's Health Initiative and HERS I and II.

Q. Right. I understand that those -- that those indications for the product turned out not to be consistent with the WHI. My question was a different one.
Is it your view, sir, that the 3,000 studies that are out there are all wrong now in light of WHI?
A. I think they've been updated.
Q. Have you done an analyis of any of those 3,000 studies?
A. I've -- I've read some of the studies. I don't know how you would use the term "analysis." But I've read the studies and I've read the Women's Health Initiative.
Q. Which studies have you read?
A. I don't recall.
Q. When did you read them?
A. I read them around the time that the WHI came out. So that would have been around what? 2002?
Q. Would you agree that a P&T committee should assess randomized clinical trials?
A. Yes.
Q. And assess outcome data,

pharmoeconomic studies?
A. In the context as I've testified to this point, yes.
Q. And would you agree that economic considerations should be secondary to the decision about the safety, efficacy, and therapeutic need for the drug?
A. In general, yes.
Q. And would you agree that legitimate reasons to exclude a drug from formulary could include the fact that the P&T committee views that the study that has been done on the product is not -- is not a particularly strong study?
A. Usually there's not just a study that a committee looks at. Generally there's -- there's a multitude of studies. Most of them relate to the studies that were performed in the process of gaining FDA approval.
That's a point that I probably should make here. In general, the P&T committee is looking at drugs as they come into the market. They're not looking in a systematic way at all the drugs that are in the market already. So unless a drug that's on the market that has previously been

assigned to one of the categories has something arise about it that -- for instance, again with your client and diet medications, when it becomes apparent that a very serious complication like pulmonary fibrosis is arising, that would trigger a reevaluation of a drug and likely withdrawal from the formulary. But in general, we're not looking back at drugs that are already there.

Q. Okay. Let's go back to the question I asked you.

A. Okay.

Q. Okay. Is it legitimate for a P&T committee to exclude a drug from -- from a formulary because there is a weak study in their view?

A. Again, not usually one study will affect it. If there's a preponderance of evidence that this is a weak drug based on the literature, it would be relevant. However, it has been my experience and the experience of peers that I've visited with that it's -- it would be exceedingly rare for a drug to make it through the FDA process that looks like that.

Q. So it's very rare to have a drug

approval with just one study?

A. Yes.

Q. Okay.

A. By the -- by the FDA.

Q. Right. Would you agree that it's rare for a drug to be approved by a P&T committee if there's only one study that is -- that is supporting it?

A. Again, it depends on the drug. If -- if we're talking about a drug that in essence is similar to something that's else on the market -- I assume we're talking about Cenestin here. I may not be.

Cenestin was viewed by the medical community essentially as a generic to Premarin. It did not meet the strict criteria of a generic because it lacked some of the 17 herbs and spices that went into Premarin. But in general, the use of a conjugated estrogen or estrogen replacement therapy in the market had been well established when Cenestin came on the market.

Q. And sir, when you say that -- that the medical community viewed Cenestin as the equivalent of Premarin, what's the basis for that

statement, sir?

A. It was the way the drug -- drug was marketed. It was the way the drug was -- and again, I'm stretching this analogy to generic.

The bigger point I was making is that the whole area of hormone replacement therapy was well established in medicine. It wasn't like we were bringing a new drug here that had never been used. The issue was is -- was there something about Cenestin itself that was dangerous, and the level of -- the level of proof would be lower in that instance than it would, say, for a new antibiotic that had never been used for, say, a fourth-generation cephalosporin. That -- that would get a lot more attention if there were no other fourth-generation cephalosporins on the market.

Q. Okay. So if I understand correctly, if you just answer my question, is it your -- what is the -- strike that.

What is the basis for your conclusion that the, quote, medical community viewed Cenestin and Premarin and the other estrogen drugs, I think you're saying, as all

equivalent during the '99-2000 time period?

A. I'm not saying all of the drugs. I'm saying that in the 1999 period the use of conjugated estrogens was well established in the marketplace and that the physicians in general viewed Cenestin as another conjugated estrogen.

Q. When you say "physicians in general," do you think you can speak for all physicians, sir?

A. I can -- going back to yesterday and the issue did I, for instance, do a survey of physicians and -- no. I will tell you based on my experience working with physicians that that was the general impression.

Q. All right. And what physicians are you -- are you referring to that you spoke with that gave you the impression that Cenestin and Premarin were equivalent products?

A. This -- this would go back to 1999 --

Q. Yes, sir.

A. -- which is some time ago, and it would involve conversations in the hallways or in the hospitals with doctors that I came in touch

with as we chitchatted about events in medicine.
Q. And so in 1999 and in 2000, you were working as -- working out your -- your computer device for RxPhysician and you were a -- anything else that you were doing during that time period?
A. I was at that time doing several things. I was involved in RxPhysician. I was involved working with Longs Drugstores as a consultant. And my major area of involvement was working with doctors to enhance the professional relationship between the retail pharmacy and the prescribing physicians. And I was working with Casio Manufacturing to bounce their ideas for design of -- of their hardware to the needs of the practicing physician. So all of those activities would have put me into daily contact with physicians across the country.
Q. Okay. And there's hundreds and hundreds of drugs in the United States, correct, that are on the market?
A. Yes.
Q. Okay. And is it your testimony, sir, that you talked with all of these doctors about an inexpensive product like Cenestin?

A. No.
Q. How -- how many did you talk with about Cenestin and Premarin, sir?
A. I'm saying that it came up in conversations that there was a new conjugated estrogen coming on the market and that it was generally viewed as being similar to Premarin.
Q. Okay. And -- and I assume that those conversations would have been with OB-GYNs or primary care physicians; right?
A. Generally, yes.
Q. All right.
A. I talked to lots of physicians beyond that, but yes, it will have been --
Q. You would have been talking to brain surgeons about Cenestin coming on the market?
A. No, no, no. It would have been -- it would have been relevant conversations to their practices.
Q. Okay. And how many of these conversations did you have with physicians that involved Cenestin or Premarin?
A. I would have to just give you an estimate.

Q. Give me your best estimate.
A. I'd say I probably visited with 25 to 50 physicians on it.
Q. Okay. And do you think from your visit to 25 -- your visits with 25 to 50 physicians -- I assume these were conversations principally in California.
A. Principally.
Q. -- that you --
A. And Hawaii.
Q. -- that you can now state that the medical community viewed Cenestin and Premarin as equivalent products?
A. That's not really the direction that I understand we're talking. You -- you were asking me as a member of a P&T committee what -- whether or not one study would be appropriate or not for considering a drug, and I was telling you that it was unique in this case and I was buttressing it with that comment. I'm not making the statement that I have done a market survey of physician attitudes as to whether it was a generic drug or not.
Q. You haven't done that; correct?

A. No.
Q. All right. And are you trying to say that the medical community in general viewed Cenestin and Premarin as equivalent products in 1999?
A. What I'm -- what I'm saying is that if I were on a P&T committee that was active at that time and I was presented with a drug like Cenestin, I would not necessarily ask for the same number of studies that I would for another drug that was unique or new in class.
Q. Let's try my question one more time.
Are you saying that you speak for the medical community and that in '99 and 2000 the medical community in the United States viewed Premarin and Cenestin as equivalent products?
A. I do not speak for the medical community and I am not attesting that that was the attitude of the medical community in those time periods.
Q. All right. In fact, the FDA took the position that they were very different products, didn't they?
MR. COHEN: Object to the form.

A. They took the position that they were not alike enough to be -- so that Cenestin could be a generic product.
BY MR. DOBIE:
Q. All right. And they also took the position that they weren't going to approve it for all of the same indications that Premarin had; correct?
A. Correct.
Q. And have you seen any studies in terms of whether physicians, in fact, view other estrogen products as being equivalent to Premarin?
A. I don't recall that I have. I can tell you why -- why physicians were interested in this. We haven't discussed it. If you want.
Q. Sir, I'm happy to come to Sacramento and do your deposition there too.
A. I'm just offering.
Q. Okay.
A. That's why I --
Q. What I want you to do is answer my questions.
A. I'm happy to do that.
MR. DOBIE: Why don't we mark this

as the next exhibit.
* * *
(Whereupon, Gibson Exhibit 19 was marked for identification.)
* * *
BY MR. DOBIE:
Q. I hand you what's been marked as Exhibit 19. Sir, let me draw your attention to Exhibit 19 and ask you if you've ever seen this document before. It's a document that has market research concerning the Premarin family of products.
A. I don't recall having seen it. I might have seen it during the Duramed case and not quoted it, but I don't -- I don't recall it.
Q. Were you aware that the physicians were surveyed concerning their attitude towards Premarin?
A. I'm -- I'm not surprised they were, but I didn't recall that.
Q. All right. And if you turn to page 131728, this is a document that describes a physician survey that was undertaken, and -- and that's the type of survey, sir, that you have not

done in this case; correct?
A. All right. Now, this -- this is a graph -- you're talking about the graph?
Q. I'm talking about, yes, the graph, sir.
A. Okay. So the graph is attributes of Premarin --
Q. Right.
A. -- among OB-GYN and PCP physicians.
Q. Yes. And you have not undertaken any type of study like this; correct?
A. No.
Q. And as indicated in this study of physician perceptions of Premarin, that only 26 percent of physicians believe that estrogens are the same and can be used interchangeably; correct?
A. That's what this shows, correct.
Q. Do you have any -- any reason to disagree with that? You haven't undertaken any of your own research; right?
A. No.
Q. Is it your view, sir, that Cenestin and Premarin have similar clinical results?
A. Yes.

Q. Okay. And what's the basis for you to provide an expert opinion that Cenestin and Premarin have similar clinical results?
A. Well --
MR. COHEN: Object to the form to the extent that you're asking him whether he's presenting an expert opinion on that topic.
BY MR. DOBIE:
Q. Are you, sir?
A. No.
Q. Okay. Can you cite to any treatment protocols, any usage guidelines, or other clinical information that advocates the use of Cenestin over Premarin?
A. Most of what I'm aware of is that the class of drugs as -- as conjugated estrogens have effects and that there's not differential effects.
Q. And what studies are you referring --
A. These are primarily based on --
Q. Can I finish the question, please?
What studies are you referring to

that says it's conjugated estrogens as opposed to Premarin?

A. Well, that's a good point. The issue that I'm relying on most heavily is HERS I, II, and the overall Women's Health Initiative.

Q. Okay. All of the research -- let me -- let me back up.

Are you aware of any research that relates to Cenestin beyond the initial 125-person study that was submitted to the FDA?

A. That's the one I'm familiar with.

Q. Okay. Are you aware of any others?

A. No.

Q. And are you aware that in that study two-thirds of women had to take two tablets in order to obtain relief from vasomotor symptoms?

MR. COHEN: Object to the form.

A. I'd have to review the study, but I'm not surprised. I have read it, but I'm not -- I don't have it with me now.

THE VIDEOGRAPHER: This is the end of Videotape No. 1. The time is 11:12 a.m. We're now off the record.

* * *

(Whereupon, a discussion was held off the record.)

* * *

THE VIDEOGRAPHER: This is the beginning of Videotape No. 2. The time is 11:14 a.m. We're back on the record.

BY MR. DOBIE:

Q. Sir, just to follow up on that, you're not contending that conjugated estrogens is its own unique therapeutic class, are you?

A. No.

Q. The selection of drugs to a formulary, sir, would you agree that it's -- although there are rebates that are -- that can be factored into the equation, in the first instance, the most important -- the most important issue is still the clinical effectiveness of the product?

A. And its safety.

Q. And so, for example -- this is a document, sir, marked as Exhibit 20.

* * *

(Whereupon, Gibson Exhibit 20 was marked for identification.)

* * *

BY MR. DOBIE:

Q. This is a document that you cited in -- in your report; correct?

A. Correct.

Q. And looking at Page 29, at the top it notes that -- "What is the Role of PBMs in the RX Decision-Making Process" and it states, first bullet point, "Prescription decision-making process is still driven by physician and patient." Do you see that?

A. I do.

Q. Is this consistent with -- with your view?

A. No. That is a -- that is a worthy goal, but I think that the industry as it's now structured has sidelined the deliberative process for physicians and pharmacists.

Q. Right. So you don't -- you don't agree that this is -- this is a correct statement, even though it's in a document that you yourself cited in your report?

A. I think there is many qualifiers to that -- that statement that you've identified. It's correct in that a prescription cannot be

filled without -- a drug cannot -- a prescription drug cannot be obtained without a physician writing a prescription. So if -- if you define it in that narrow sense, that's a correct sentence. If you -- if you, in viewing that sentence, do not factor in all of the factors that go into influencing the decision, then it's wrong.

Q. All right. Is it your view, sir, that -- that the patient desire for a particular product or physician desire to prescribe a particular product is less important than other factors?

A. It's important. It's -- there is just significant inhibitors that prevent that from being a reality.

Q. And -- and the inhibitors you're talking about I assume are formularies?

A. The report deals with a whole host of factors, including formulary, positioning on the formulary, and enforcement procedures that are in the market to drive utilization in conformance with the formulary.

Q. Okay. Would you agree that in many instances formulary status doesn't necessarily

have a major impact on physician prescribing patterns?

MR. COHEN: Object to the form.

A. I think formulary position for the major contractors has a significant influence. So I would disagree with that with those modifications.

BY MR. DOBIE:

Q. Isn't it true, sir, that customers will develop their own formulary and that customers developing their own formulary within these major PBMs that you're speaking of, that in turn can be what, in fact, influences patient demand?

A. It can. And I quoted sources from Wyeth's own documents that support that as well.

Q. Right. And -- and that would have been another avenue for Cenestin in the marketplace; right? They could have gone to individual plans and tried to have their drug put on particular plan formularies; correct?

A. They could. Again, you have to look at the time frames. Back in 1999 -- from 1999 to 2004, this market evolved. The attention paid by

the marketing side of the pharma houses has been more and more concentrated on the consultants and the independent trust funds.

Q. All right. And so to answer my question, in addition to trying to market to PBMs, Duramed could have -- as you indicated Wyeth is now doing, could have called on particular plans and had the plan put Cenestin on that particular plan's formulary; correct?

A. Yes.

Q. And do you know whether this was the case in 2001?

A. Do I -- the question is do I know that -- that Duramed --

Q. Do you know whether that option was available to Duramed in, say, '99, 2000, 2001 or is it your view that you can only do that in 2004?

A. No, no. If that's your understanding of what I said, that's inaccurate.

I -- what I -- what I said was that any time an underwriter had a pharmacy benefit and they had their own consultants or their own P&T committee, they had the option of modifying the formulary. That's one of the variables that is

involved in bringing a client aboard with a PBM. They can look at the formulary structure and they can look at and design the copayment structures and then the PBM administers the benefit based on those understanding -- those agreements.

Q. Now, sir, you've been involved in litigation between Cenestin and Premarin and everything going all the way back to 2001; correct?

A. I was involved in one instance, yes.

Q. And you've been the head of the P&T committee at PCN since 2002, although I understand your first meetings weren't until 2003; correct?

A. Correct.

Q. And at any time between 2002 and the present, has PCN ever considered adding Cenestin to formulary?

A. Not that I'm aware of.

Let me back up. I do not know how -- I know that Cenestin was probably classified as an also-ran drug in the -- in the category of the three categories that I mentioned, in that it's now available but not in a preferred position. So knowing the -- knowing the

methodology of how this process flows, this was activity that would have been conducted at the AdvancePCS level with P&T committee's evaluation prior to the handoff back to PCN.

Q. Okay.

A. So that -- I'm sorry, but let me just -- we have not revisited as a committee the entire group of drugs which would be estrogen replacement.

* * *

(Whereupon, Gibson Exhibits 21 and 22 were marked for identification.)

* * *

MR. DOBIE: For the record, Exhibit 21 is a copy of the PCN preferred drug list for 2004 as -- as provided on the Internet.

Exhibit 22 is copy of the PCN Medicaid formulary for 2004 available the same way.

BY MR. DOBIE:

Q. And sir, first, can you identify this as the PCN formulary for 2004?

A. I can. It is not a complete list, but I can.

Q. But at least it covers the women's health category with osteoporosis, calcium regulator agents, correct, and estrogens?
A. To the second-tier level, yes.
Q. And you mentioned that perhaps the situation at PCN may have been that you inherited the AdvancePCS formulary?
A. Yes.
Q. Right. Well, if in 2002 Cenestin was the product that was on the second tier at AdvancePCS and Premarin was not on the formulary, can you explain how it is that PCN, in creating its formulary, put Premarin on but not Cenestin?
A. I can speculate. I wasn't part of the decision.
Q. I don't want you to speculate. Do you know -- do you know how the decision was made?
A. I'm sure that there was -- no. The answer is no.
Q. And did you at any point after getting involved in litigation relating to Cenestin and Premarin going back to 2001 -- have you ever asked any of the staff members at PCN to review Cenestin?

A. No.
Q. And have you ever asked them to undertake any review of Premarin?
A. No.
Q. Do you know what the financial ramifications are of having Premarin on the PCN preferred drug list as opposed to Cenestin?
A. The rough numbers, yes, and that is demonstrated in my report on Page 42 with the rebate example.
Q. Okay. But I'm talking about PCN. We can look at your rebate example for a moment. This rebate example, this doesn't -- this isn't PCN; correct?
A. No. What this is is an example -- the thrust of this particular example is why it is -- why a -- why a PBM could not risk breaking an exclusive contract with Cenestin and how Cenestin could never make up the difference.
Q. All right. Well, let's back up. We'll come back to this soon enough.
Do you know whether or not PCN had an exclusive contract with Wyeth?
A. I don't know.

Q. And -- and do you know whether or not it has any sort of reimbursement agreement with Wyeth?
A. I do not.
Q. And so in terms of why it is that PCN has Premarin on the formulary as opposed to Cenestin, you're speculating that, in fact, there is a reimbursement agreement that offers larger rebates to PCN than what Cenestin rebates they could receive from --
A. I do not know.
Q. You don't know. Okay.
Do you know -- you mentioned yesterday that -- that Cenestin is now on the third tier at PCN.
A. Yes. If you type in the drug finder on the -- on the website and type in "Cenestin," it will indicate that it's on formulary, but when you print out the preferred list, which is what this is, it does not appear on it. So it's -- it is -- it is not a second-tier product.
Q. Is the -- do you know how it ended up being on the third tier?
A. No.

Q. The products that are listed on the preferred drug list, estradiol, estropipate, and Premarin, are these all products that are viewed as substitutable for Premarin?
A. These are -- these are drugs that are clinically accepted as -- for use in hormone replacement therapy.
Q. And are they substitutable, to your understanding?
A. Which of the drugs you were indicating?
Q. Would estradiol and estropipate and Premarin all be substitutable one for the other?
A. Yes.
Q. And is the idea to have a number of different products on the formulary so that the doctors that are using the PCN formulary have some -- some options?
A. Correct. And again just to say I'm speculating there, just like I would have had to speculate earlier. I don't know that for a fact, but it -- it's reasonable that they were putting it there as an option.
Q. You're the head of the P&T

committee. Do you -- do you want to have a number of different options like that on the formulary?

A. Yes.

Q. Now, on Page 40 of your report, you talk about how -- let's see here.

In the second sentence after "Rebate definition," you have Wyeth leveraged its dominant position in the oral estrogen -- oral conjugated estrogen market, took the above rebate contracting to a more aggressive level. "Wyeth entered into contracts with PBMs and MCOs to inhibit a competitor's entrance into the marketplace."

Let me ask you first. You mentioned that Wyeth entered into contracts, plural. Do you have any knowledge of there being multiple contracts that Wyeth entered into that inhibited a competitor's entrance into the marketplace?

A. I am aware that the contracting manual that Wyeth created in 1995 had a structure for creating rebate agreements within their contracts and that -- that one of the critical features was to have the PBM list Premarin and its family of drugs as the sole conjugated estrogen, and that appeared in most of the contracts that I

reviewed.

Q. Okay. Do you know whether or not the sole conjugated estrogen language appears in -- you say most of those that you reviewed. How many contracts did you review?

A. I don't recall how many. You've seen the documents that I have reviewed and you know the documents that I've cited in my report.

Q. Right. And what I saw was you didn't actually receive too many entire contracts. You got pages of certain contracts. Is that correct?

A. Whatever was in the -- whatever was in the -- in the pages that you were provided.

Q. Okay. And so when -- when we pulled the pages that we were provided, it looked like you had received pages of certain contracts that had the sole conjugated estrogen language.

Does that -- does that refresh your memory of how you looked --

A. Yes.

Q. -- at these contracts?

A. As I recall, I had the terms for the rebate agreements, and -- and there were other

factors, including administrative fees and so forth, that I also cite in my report, but I was particularly interested in this rebate structure.

Q. Do you know how many contracts you reviewed in total?

A. I'd say I probably looked at somewhere between 50 and a hundred.

Q. Okay. And do you -- is it your testimony that most of those had the sole conjugated estrogen language?

A. Yes, most of them seem to have the sole conjugated estrogen exclusive language in the contract.

Q. And in -- I just want to be clear, because we got the list of those that you've seen and we haven't seen anything like 50 or a hundred contracts being on that list that you were provided.

A. All right. Well, whatever was on the list --

Q. That's how many you reviewed.

A. -- is the number. I'm just pulling a number. It seemed like a lot of contracts I looked at, but I didn't click it off and count how

many I reviewed.

Q. But most of those that you were provided had the sole conjugated estrogen language?

A. Correct.

Q. Are you aware of the fact that, in fact, most of the reimbursement agreements that Wyeth had with managed care do not have the sole conjugated estrogen language?

A. In which year?

Q. In any year.

A. In any year?

Q. From '99 to -- to the present.

A. I'm not aware of that.

Q. The example that you cite on Page 40 here is actually to the -- not to the contract resource manual, but that's actually pages from the Medco agreement. Did you review the Medco agreement?

A. I did.

Q. And does -- does the -- does the Medco agreement or the amendment to the Medco agreement somehow factor into your opinions?

A. Yes.

Q. How so?
A. If you could give me the agreement, I'll -- I don't -- I don't -- I'm not -- I don't have on the top of my mind what was in the agreement. So If you can give me the agreement, I could answer that.
Q. You know what? I don't have it handy. It wasn't one of the things that I was going to walk you through. I assumed that since you had it cited in your report you would know what you were referring to.
A. I would have -- because I cited it in my report, I would have indicated that there were factors in the agreement that would have inhibited Cenestin's entrance into the market. I didn't -- I didn't in citing this indicate what exact things they did in the contract but that there were inhibitors.
Q. Do you know whether or not these contracts allowed a P&T committee for any PBM to simply add another product to formulary if in their clinical judgment that was the most appropriate thing without having any impact on rebate dollars?

A. Let me -- on Page 66, I have four documents cited where Premarin was required to be the exclusive and sole conjugated estrogen or preferred estrogen on formulary, and I cited MedImpact, National Prescription Administrators, and Caremark. Do you see that?
Q. I do.
A. Now, I -- whether or not there was language in the contract that said that the -- that either the client or the P&T committee couldn't override for some medical reason -- I don't recall that being in there, but I wouldn't be surprised -- it would entail a fair amount of liability to say that this contract would supersede medical judgment or medical -- the medical literature.
Q. All right. So you don't disagree with the notion that PBMs, despite the Wyeth contract, could have had a meeting of their P&T committees and if they decided that clinically they thought Cenestin was a better product to have on formulary, that they could have added Cenestin over Premarin irrespective of the -- of the contract?

MR. COHEN: Object to the form.
A. Again, remember how a P&T committee works. A P&T committees determines whether a drug is acceptable. It doesn't determine what its position on a formulary is going to be or what relative positions it's going to have on the formulary. So in general, a P&T committee might say that a drug needs a bit more time coming into the market, but you -- you -- it's not common for the P&T committee to be involved in the micromanagement of the formulary.
BY MR. DOBIE:
Q. It is common for P&T committees to say that it might -- a product might need to be on the market a little bit longer before they would add it, though; correct?
A. That -- that would be an acceptable conclusion.
Q. And -- and your idea that P&T committees decide whether a product is acceptable or not for inclusion on the formulary but don't get involved in the question as to whether and where it should fall as either a first, second or third tier or in a three-tier formulary or some

other structure, that's based upon your experience; correct?
A. It's my experience. The one -- the one alteration to what you just said is that if we list a drug as unique, that puts it in a different category.
Q. All right. And -- and to go back to my question about these contracts that you're referring to, you're saying it's not usually the case that the P&T committee would -- would, in fact, decide to take a drug like Cenestin and put it on the formulary and take Premarin off. You're not disputing that the agreements, though, would have given the PBMs the option of doing so if they had wanted to do so?
A. For medical reasons?
Q. If they determined in their sole judgment that they wanted to add Cenestin and take Premarin off, they could have done so; correct?
MR. COHEN: Object to the form.
A. The P&T could do that or --
BY MR. DOBIE:
Q. The PBM.
A. The PBM could do that.

Q. Right. Because the contracts -- here's what I'm getting at.

Did you read enough of them to see that they all have either a 60- or a 90-day out clause to basically get out of the contract or a provision that says that the P&T committee, if they review a product and decide they want to put another product on and take the existing Wyeth contract off, they have the option of doing so?

A. I'm aware of that.

Q. Okay. Let's talk about Page 43 of your report. You have a heading there that talks about factors influencing rebate levels.

Is it your experience that generally the number of drug product classes of the pharmaceutical manufacturers' products that are included in the formulary can impact the amount of rebates?

A. The question -- let me repeat the question. I just want to make sure I've got --

Q. I'll restate it. You've set forth here a number of factors that may influence the level of rebates provided to PBMs; correct?

A. Correct.

Q. And is one of those factors the number of drug product classes of the pharmaceutical manufacturers' products that the PBM includes on the formulary?

A. Most formularies have drugs in all of the classes. Where -- where am I not getting your answer?

Q. I'm reading your -- your No. 1 here, okay, and I just want to make sure I understand this.

Is it true that one of the factors that may influence the level of rebates that's provided to the PBM or the MCO is the number of drug product classes of the pharmaceutical manufacturers' products that the PBM includes on the formulary?

A. Yes.

Q. Okay.

A. And that's consistent with Wyeth's own documents. I believe they refer to it as the contracting platform.

Q. All right.

THE VIDEOGRAPHER: We're going off the record. The time is 11:42 a.m.

* * *

(Whereupon, a short recess was taken.)

* * *

THE VIDEOGRAPHER: We're back on the record. The time is 11:49 a.m.

BY MR. DOBIE:

Q. Sir, if I can draw your attention to Page 40 of your report, and we covered this briefly already, but in the -- in the third paragraph, that talks about the formulary position and the number of formulary drugs within drug product categories are key factors which impact the drug's sales volume and market share within the therapeutic class. Remember we discussed that yesterday briefly?

You have to respond verbally.

A. Correct.

Q. All right. What I wanted to ask you about is other things that -- beyond a formulary position that may impact the drug's sales volume and the market share.

Would you agree that physician demand can impact the formulary -- can impact the

drug's sales volume and market share?

A. Yes, particularly in the nonmanaged care market --

Q. And --

A. -- with Medicare.

Q. And even within the managed care market, physician demand can influence a drug's sales volume and market share; correct?

A. Yes.

Q. And consumer demand can in turn impact a drug's sales volume and market share?

A. Yes.

Q. And attractive pricing, same thing? Can impact drug's sales volume and market share?

MR. COHEN: Object to the form.

A. Drug pricing is probably the weakest because both the prescribing physician and the receiving patient are virtually blinded to that variable.

BY MR. DOBIE:

Q. Okay. And how about FDA indications for a product; can that impact a drug's sales volume and market share?

A. Yes.

Q. How about available dosages of a product; can that impact a drug's sales volume and market share?

A. Yes.

Q. But I understand your view, which is that essentially the formulary position itself can have a significant impact on the -- on the success of a drug product in terms of sales volume and market share; right?

A. That was my opinion and it was Wyeth's opinion.

Q. All right. And is it your view that -- that formulary position causes physicians to prescribe a certain drug?

A. Yes.

Q. All right. And if that's the case, then don't you think that -- that a particular PBM could essentially decide not to put Premarin on formulary, not to have an agreement with Wyeth, and instead put Cenestin on formulary, provided that Cenestin offered a lower price and a greater rebate?

A. It would be highly unlikely.

Q. But they could do that; right?

A. They could. In the -- in the abstract universe of possibilities, yes.

Q. Okay. But if -- if formulary -- here's -- here's what I'm getting at. If formulary -- maybe -- maybe -- maybe I don't understand.

We just went through sort a litany of different things that -- that go to pharmaceutical demand, physician demand, consumer demand, pricing being lesser and dosage forms and so on.

I thought you were saying that the most important thing is formulary placement. Do I -- am I incorrect in that or do you think they're all relatively --

A. No. I think that formulary placement in the managed care environment is probably the cardinal issue --

Q. In terms of whether --

A. -- driving demand.

Q. In terms of driving demand. Okay.

So if that's the case, why not -- forget about PCN. Why not simply remove Premarin from formulary and put Cenestin on formulary

assuming that Duramed or now Barr Labs was willing to pay larger rebates or offer a lower cost product?

A. It would be highly unlikely that any PBM would have offered Cenestin as a replacement for a well-established drug like Premarin.

Q. Okay. And why is that?

A. Because it never was designed or viewed as a replacement product. It was -- it was a product that some patients would have used or preferred.

Quickly, a number of patients found the use of pregnant mares to be objectionable and wanted an alternative. Some women found the whole idea of taking a product from that source as being -- they were squeamish about it. Some women found, particularly active women, that when they sweat with Premarin, their sweat, they reported, smelled like urine and they found that offensive.

So it would have been a percentage of the market that this -- oh, and some -- some people seemed to be persuaded that there was a newer delivery technology that allowed for a more sustained delivery of the drug to the system.

So for all of those reasons, there were people that would have preferred Cenestin to Premarin if it occurred. Wyeth's own documents show that it's critical which drug a patient gets started on initially. You know, the new starts are referred to in many of Wyeth's documents that I -- that I reviewed, and that's consistent with my experience. So that it would be very traumatic to have all of these patients currently on a product like Premarin and do a complete replacement.

Q. Are you familiar with situations at PCN or with AdvancePCS where they've gone from having a -- let's say a PPI, one product being the preferred drug that everybody within the system can buy at the preferred price and they switch to another PPI?

A. It's not an analogous situation, because in most classes you have loyalty within the class but you don't have a situation where there is one dominant drug with a new competitor coming in that you would replace the well-established drug with. You -- you generally have subsets of the market with each of the products

that are available.
Q. All right. And so you're saying that Premarin in essence had consumers that were loyal to the brand as opposed to the class?
A. That's what makes this whole discussion so fascinating is that you have a manufacturer and a product that are very well established, that as a result of that position provide substantial rebate revenue and contracts that place those revenues at risk with the out clause that you referenced earlier that make it very difficult for a new competitor to come in and compete on the basis of patient acceptance, doctor acceptance, price, or any other variable that we went through on the list.
Q. Okay. But if -- if on the other hand, let's say, Duramed had instead launched this product after obtaining all the same FDA indications that Premarin had, had done more clinical studies, had done head-to-head comparisons and things that you talked about the physicians are looking for, had done an economic model study for this product, all of those things, don't you think that -- that a P&T committee could

have made a decision to simply have switched to Cenestin and they could have essentially moved their patients to that product from Premarin, again assuming that it's the formulary position that derives the success and market share of the product?
A. In the abstract, they -- they had the opportunity to do that. It would have produced an avalanche of complaints, because the patient is being asked to change a pattern that they've had for a number of years.
Q. Okay. And here's what I guess I don't understand.
Are you saying, like in the PPI category, there are -- you are aware of situations, right, where PBMs have switched, you know, from one year to the next of what's the preferred PPI?
A. Yes.
Q. All right. And are you familiar with years where a PBM will switch from the preferred oral contraceptive from one year to the next?
A. Yes.

Q. Okay. So -- so why could they not do the same thing as it relates to Cenestin and Premarin?
A. Okay. I thought I -- we can go over it again. It's a unique class -- not a class. It's a unique group of compounds within this --
Q. Premarin?
A. Yes. Within the conjugated estrogen with a high degree of patient loyalty. And the introduction of a product like Cenestin would appeal to a subset of people who even knew that it was derived from mare's urines or had observed that they were -- their -- their perpsiration smelled like urine or that had read about the delivery mechanism for the drug. That's a very small segment of the market.
So it -- it was expected that -- that this product would be a viable competitor for a subsegment of the conjugated estrogen market but not be a replacement.
Q. What -- what do you think -- Cenestin -- when you talk about just a viable competitor in the marketplace, what do you see as -- as where it -- where it would have been? Do

you have an opinion on htat?
A. I don't. I can tell you that it was -- it was Wyeth's goal to hold it at 2 percent or less. My bet is that had it not had all the factors we've been discussing, it would have been more than that. I don't have the competence to tell you how much.
Q. You talk about in your report -- you have a number of pages that talk about the Cenestin impact model.
A. Yes.
Q. That's on Pages 74 and 76. That sort of relates a little bit I think to the discussion that we're having or it may.
All right. You talk about on Pages 74 through 78 the fact that Wyeth generated analysis that could be used with various managed care companies about the impact that would happen if a particular managed care organization -- your example is Pacificare -- if they moved from Premarin to Cenestin in terms of the loss of rebates; right?
A. I believe it goes from 74 to 76.
Q. 76.

A. Okay. Yes.
Q. And -- and based upon what you were telling me yesterday, it sounded like managed care organizations do their own analysis in terms of -- or should do their own analysis of the impact of moving from one product to another within a particular therapeutic class; is that true?
A. That's reasonable. However, these were all generated by Wyeth itself and created by account and presented to them -- it's my understanding it was presented to each of the accounts. So it was -- whether they did it or -- themselves or not, Wyeth made very clear what the effect would be if they violated the exclusive arrangement within the contract and the market share for Premarin decreased.
Q. Okay. But as I understand what you're saying then, this information, though, is no different than what the customer might be generating on their own anyway?
A. They might. Correct.
Q. All right. And so -- so it's just -- your complaint is that Wyeth did this themselves as opposed to the customer?

A. No. What -- my -- my complaint isn't that they did it at all. I'm including it as a rather clear example of the downside that a monopolist can exert in a marketplace.
Q. Is -- and so is it -- is it your conclusion that Wyeth is a monopolist?
A. We went over this earlier and I defined for you how I viewed it. I'm not a lawyer and I'm not defining this from a legal perspective. Another way -- you could substitute another term for this, what I'm testifying, that it is a dominant market player, that a dominant -- established dominant market player can -- can hurt customers to compete, whereas not -- groups that are -- do not meet that category have to compete on the basis of positives.
Q. Okay. But here's what I'm getting at. If the customers have this information anyway, all right, what's the big deal about Wyeth doing this type of analysis itself? Don't you think that a well-trained sales force should have information about the financial ramifications of their contract relationships with their customers?
MR. COHEN: Object to the form.

A. I do think they should.
BY MR. DOBIE:
Q. All right. And do you know, in fact, whether or not any of these market cost analysis like this Pacificare one were actually presented to any customers?
A. It's my understanding that they were presented, but I don't know. I read various documents on this list, including memoranda wherein there were reactions to the presentations by the customers themselves. I don't have a list of every single account and what their reaction to it was when this was presented to them.
Q. Here's the reason I ask. I can only think of one, all right, in the record. I've been living in this case for a long time.
Are you saying you've seen other documents that would indicate that this cost analysis was presented -- and Brooke, maybe you know of another one, but I can only think of one where this cost analysis was presented to a customer. So I'm curious what the basis is for your -- for your testimony that this market cost analysis was, in fact, presented to customers?

A. Well, I suspect --
MR. COHEN: Objection. I just want to object to the form to the extent you're referring to this cost analysis as opposed to oral representations or that kind of thing.
A. Let me see. I have multiple examples where documents reference conversations with the client as to the contract terms. I don't have a clear paper trail as to how often this was actually presented.
An example of that is on Page 73 at the bottom, where the document -- it's an internal Wyeth document concerning Foundation Health Plan dated May of '99 where the value of the Premarin contract in face of Cenestin, decreasing market share, and key accounts was discussed. So that's the sort of document that it's -- it's inferred, but it's not -- it doesn't say there that he sat down and went over it.
BY MR. DOBIE:
Q. Do you -- do you think it would have been possible, for example, at Pacificare or any of these other companies to have moved a portion

of their business to Cenestin and not achieved any loss of rebate dollars?

A. I think if they had a contract with -- with Wyeth that was an exclusive or that had some of the other factors that I've put in my report, that there was a clear threat that using the 30- or 60-day opt-out clause, that Wyeth could cancel their contract or their rebate contract -- their reimbursement contract and that that would have a substantial effect on the organization's bottom line.

Q. Okay. You cite Aetna in your -- in your report. Do you know, isn't that, in fact, what happened and what has happened at Aetna? They've decided to take rebate dollars from Duramed and a number of other companies and put Premarin on the third tier?

A. I'm aware that that was the case, and it was unique, and it was very -- a very interesting case and -- and taught us a lot about the market, which I discussed in my report.

Q. Okay. And one of the things in the marketplace is somebody like Aetna can actually be better off financially by having Premarin on the

third tier, forcing its patients to pay for the product at the third-tier copay, but in turn get rebate dollars on Cenestin and other generic products; right?

A. I'm --

MR. COHEN: Object to the form.

A. I'm not sure that that happened and I'm not sure that was the end result. I don't know. I know that if Premarin had these kinds of rebate structures with Aetna and they moved the patients to -- they moved Premarin to the third tier and lost the rebate dollars and replaced it with Cenestin, with even an enhanced rebate contract, that it may not have and in all likelihood would not have made up the difference.

BY MR. DOBIE:

Q. Okay. But there's two ways that a plan could be reimbursed for the loss of rebate dollars. Okay. On the one hand, they can get the rebate dollars from -- like in the case of Aetna, they might be able to get them from -- for Cenestin and the other products that they put on formulary. The other thing they can do is take away the obligation to pay for Premarin

prescriptions in the first place and instead put the cost on the patients and by basically putting Premarin on a third-tier copay.

A. That question implies that the business transaction would be that the patient would pay for the drug but that the PBM would charge the client for the product.

Q. Well, in the Aetna example, okay, it's not really a PBM. In the Aetna example -- let me ask you this: Are you aware that what has happened at Aetna is just that? They put Premarin on third tier, where there's a $25 copay or higher, depending on the specific plan, and that -- and are no longer receiving rebate dollars from Wyeth but instead are receiving rebate dollars on Cenestin and other products.

Were you aware of that?

A. Yes.

Q. Okay. And so isn't that a contract strategy that Duramed could have employed as it relates to this product right out of the box?

A. It could have. It is not a -- it is germane to an underwriter like Aetna.

Q. Right.

A. It is -- it does not apply to the PBM.

Q. But certainly with the groups like Aetna or a Blue Shield of California, any of these groups that are -- that are -- have that business model, an underwriter, Aetna -- what are the others -- CIGNA, Humana, those groups, they could have all -- Duramed could have approached them with such -- with such a proposal but, in fact, didn't?

A. They could have. It would have -- it would have placed them in an unfavorable light with the customers and the -- the balancing act that they would -- would have to calculate is how much pain they would be willing to impose on the customers to implement that strategy.

Q. All right. And -- and the reason why there would be pain to Aetna or whatever company tried to achieve that strategy is that you might have patient pushback in terms of they still want Premarin?

A. Exactly. Human beings don't like change.

Q. All right. And -- and I guess what

I'm getting back to then is the -- it's not simply formulary position that determines the success of a product then. It's -- patient demand can play a major role and doctor demand can play a major role in terms of the success of a product irrespective of formulary position; right?

A. Right.

Q. Okay. Now, you also mentioned -- let me just ask you one more thing about that.

Do you think that -- that Cenestin could have achieved as much of -- well, I don't want you to speculate. We don't have much time. Strike that question.

Oh, spillover you talk about on Page 52. In the third paragraph on Page 52, you say the later phenomenon is referred to within the industry as the spillover effect. Do you see that?

A. Yes.

Q. And you're referring to situations where doctors essentially get used to writing a particular prescription because of a formulary and then they'll write it in a -- in a situation even where there's not a formulary?

A. That's correct.

Q. Okay. Here's what I'm wondering about spillover. To what extent do you believe that spillover may also -- that there may be spillover from other experience -- experiences that physicians encounter?

Let me give you an example. I mean, suppose a doctor writes a Cenestin prescription and it's a .625. The woman takes it for two -- two weeks and like the folks in the study need to titrate up to a larger -- basically a double dose. They get a call from the patient and the patient says this isn't working. The doctor checks, sees that there isn't a 1.25 dose for the product, and then, you know, is basically confronted with the question of what to do.

Would -- would that experience of having a problem with a patient needing to titrate up -- could that spill over into their prescribing habits in the future?

MR. COHEN: Object to the form.

A. It could. Most physicians, if they had a reason to put the patient on Cenestin, like the ones we discussed earlier, would simply double

the dose, you know, give the patient two tablets. It's not -- it's not -- it's not something that's hard for them to write, you know, a 30-day supply -- for a 30-day supply, 30 tablets or 60 tablets. It's just a change of one number on the script.

BY MR. DOBIE:

Q. Okay. But the difference would be is the patient would be out of -- out of pocket to the extent that they had to double dose, wouldn't wouldn't they?

A. If it's on formulary, are we talking about now, with the copayment structure?

Q. Let's -- I mean, do health plans allow -- it would have been double the cost, would it not, to -- for the health plan or the patient to have taken two .625 Cenestin pills as opposed to one Premarin at 1.25 dosage; right?

A. I understand your --

MR. COHEN: Object to the form.

A. I understand your point. However, it didn't make a difference to the patient, in that you are writing for a one-month supply of the drug, and that produces one copayment.

BY MR. DOBIE:

Q. Okay. But it would have been twice the cost for the plan?

A. It -- it would have been twice the cost to the plan from the one tablet.

Q. And in a physician looking at Cenestin -- I'm just wondering about spillover here -- whether having had that experience with having to double dose and basically prescribe twice the amount of the product at twice the cost of Premarin, would that -- that experience spill over in terms of whether -- their willingness to write a prescription for that product again?

MR. COHEN: Object to the form.

A. Yes, it would.

BY MR. DOBIE:

Q. And do you think that you could have spillover from physicians having written prescriptions for Premarin for 20 years that could spill over into their willingness to write prescriptions for Cenestin or other products?

A. I think -- I think that unless there was a -- either a strong demand on the part of the patient like -- for the reasons we discussed for

Cenestin or there was a push by the plan to preferentially position it, that physicians would continue to use Premarin as their preferred conjugated estrogen.

Q. Okay. And so the prescribing habit, if you will, that can spill over into their -- into their writing the prescriptions irrespective of formulary position; right?

A. Would you mind repeating that?

Q. Yes. I'm going back to what you said about how physicians frequently don't even know what's on formulary. So I guess I'm just wondering if whether physician prescribing habit can spill over such that they'll -- they will write a Premarin prescription irrespective of what is on formulary.

A. Yes. In a -- in a way you're touching on one of the critical parts of this case, that being that to concentrate the Premarin preemptive plan in the market just as Cenestin's coming on the market, which is a very vulnerable period for a new drug -- that's when all the buzz is out there. That's when the articles have been written, are in the non-peer-reviewed press.

Magazine articles are written about it. The physicians during that vulnerable phase will read about it and may -- may want to try the drug. Or the patients may have read about it and they want to give the drug an opportunity.

It's at that vulnerable phrase that they write the drug and they start getting all of these phone calls back from the pharmacy that it's not on formulary, that the cost is greater for the copayments. All of those negative factors start flooding back into his office and the physician will say, Hey, this isn't worth it. I'm not going to give this drug a try.

(Pause.)

THE VIDEOGRAPHER: Proceed.

BY MR. DOBIE:

Q. Okay. I'm just asking about sort of the other part of that -- that spillover, which is that you will have spillover as well from -- just simply from physician prescribing habits; right?

A. Yes. The term "spillover" is generally not applied to a dominant market player like Premarin.

Q. Okay.

A. It's -- one of the values of one drug in a class of four that are roughly equal to be placed as a preferred drug will have a definite spillover effect into the noncontracted business. Premarin was so -- such a dominant player in the conjugated market at -- in 1999 that it -- whatever spillover effect had been in place for 10 years.

Q. You mention how the -- you said that the launch is a -- is a vulnerable time.

Would you say it's a critical time as it relates to the -- to what the uptake is going to be in the marketplace?

A. I think it's a critical time.

Q. All right.

A. If a drug at the point of introduction to the market is -- is discriminated against effectively by marketing techniques, it -- it has a disproportionate damaging effect.

Q. Okay. In terms of other things that could have a disproportionate damaging effect, could that also include a decision on the part of the company to not seek formulary position?

A. Could you --

Q. Yes. There's -- I assume that there's a number of different things that can go wrong in connection with a launch, some of which can be caused by competitors and some of which can have to do with the company's own marketing program or the attributes of the particular product; correct?

A. Correct.

Q. Okay. And some of the things you told me about on the -- on the Wyeth side, but if we look at it from the -- from the Duramed side, other things that could have impacted the launch of that product would be, for example, not having a large enough sales force. That could impact the success of the product; right?

A. Yes.

Q. And, in fact, have you seen the literature that indicates that the size of the sales force can be one of the most important indications of the success of a product in the marketplace? And Pfizer is often cited as an example there.

A. What year are you talking about?

Q. In '99 and 2000.

A. In '99?
Q. Yes, sir.
A. In '99, it was.
Q. Okay. And would you say making a decision -- or not having samples to offer to physicians, could that be something that would go to the success of the launch in the marketplace?
A. It would be a factor.
Q. And -- and making a decision not to contract with certain major managed care organizations, could that be a factor that would go to the success of the product in the marketplace?
A. So that -- so that the -- there was no -- no attempt made in the contracting environment to be placed on the formulary?
Q. I'm just saying, would a -- would a decision on the part of Duramed to not seek formulary status at certain major managed care organizations -- could that also impact the success of Cenestin in the marketplace during this launch period?
A. Yes.
Q. And would Cenestin, not have having

the same indications as Premarin -- could that also impact the launch of Cenestin in the marketplace at the time that they launched it?
A. Yes.
Q. And would you say not having as many studies -- head-to-head studies or other literature supporting the product could have impacted the success of Cenestin in the marketplace at the time of launch?
A. Yes.
Q. And do you think that -- that if -- if those things were found to be true, that that in turn along with -- I understand you believe for Wyeth's conduct -- could carry over into -- into other years as well?
A. Yes.
Q. The Aetna situation we talked about briefly is on Page 59 of your report. You -- you talk about the success that -- or I guess the losses that Premarin has had in -- in prescriptions as a result of going to third tier; right?
A. Right.
Q. We talked about this briefly.

Again, you haven't made any examinations in terms of whether Cenestin has done any better at -- at Aetna, have you?
A. At Aetna?
Q. Yes, sir.
A. No.
Q. And -- and you haven't made any examinations as to whether Cenestin has done any better at any other places where it's gone on formulary like AdvancePCS, Humana, or Express Scripts?
A. Correct.
Q. And then in terms of what you're citing here about the impact of -- the impact to Premarin as a result of going to a third-tier formulary position, have you made any analysis as to what extent that loss could be attributed to the fact that its competitors have increased the amount of detailing or the share of voice that they are applying to Aetna, for example?
A. No.
Q. And have you made any examination in terms of to what extent Cenestin, having been on the market for a longer time period, may have had

on it improving its position, if at all, at Aetna?
A. I kind of got lost in that question.
Q. All right. Let me -- let me try that again.
Do you know whether or not any of Premarin's loss of market share could be attributed to other factors, is sort of what I'm -- what I'm curious about, and whether you've considered at all that their loss may be attributed to the fact that estradiol, for example, the generic, is doing much better?
A. This -- this chart --
Q. Yes, sir.
A. -- was included for two reasons. One, it was included to show the internal consistency in the document of the damage that occurs to a product when it goes from second to third tier. And that's consistent with prior documents that I reference in my report from Wyeth itself. And secondly, it was included as a fascinating, albeit serendipitous, experiment wherein two roughly equal underwriters, CIGNA and Aetna, behaved differently in their formulary structuring, and that being that Aetna moved the

product from second to third tier and CIGNA did not, and it gave an opportunity to look at what the effect of WHI was on the products.

Q. Okay. And -- and so you've cited the quotes from Margaret Glassman in terms of her view that WHI could only -- could only account for 15 percent of the decrease and that the 27 percent doesn't relate to WHI.

A. Correct.

Q. Right?

A. This was an interchange with Kate Moore and Margaret Glassman in the cited reference from Wyeth's own internal documents.

Q. Right. These are e-mails back and forth between them?

A. Correct.

Q. Do you know what position either of them hold?

A. Well, let's see.

Q. You've got -- actually, you've got in your report -- you say Glassman is an analyst at Wyeth?

A. Yes, I thought I had that in my report.

Q. All right. And do you know whether she undertakes this type of analysis typically at Wyeth?

A. I'm not familiar with her scope of duties at --

Q. All right.

A. -- Wyeth.

Q. And I guess what I'm wondering, have you yourself undertaken anything to examine whether or not the decrease in performance at Aetna has to do with anything beyond it not being WHI?

Let me restate that. Have you undertaken anything to determine yourself whether or not Premarin's decrease in sales there has to do with something other than WHI?

A. I did cite -- let me find where we are here.

I did cite what were copayment differentials in the market on Page 36 and I cited Wyeth's own internal documents on Page 35 demonstrating that differentials in cost that are exposed to the patient will make a difference in market share. So the report that we're discussing

now is consistent roughly with these internal documents that Wyeth had, and of particular interest to add to that was that it occurred during the time frame of WHI's coming out.

Q. All right. I understand that. I guess what I'm -- what I'm trying to understand is whether or not you've tried to make an analysis, sir, in terms of whether other factors may have influenced the decline in Wyeth's market share at Atena.

A. No.

Q. So you don't know sitting here today whether or not its decline there relates to only moving to third tier or whether it may also relate in part to things like new marketing strategies of competitors, more detailing by competitors, things like that?

A. All of the things like that would have a factor. However, it is Wyeth's own position or their consultant's -- this happened to be Putnam Associates that was working for Wyeth -- that copayment amounts at various levels definitely affect and move market. And the experience at Aetna would support that. It

doesn't address the universe of possibilities, but the -- if not the major, certainly one of the major factors driving the change in market position would have been the copayment structure for third versus second tier.

Q. Okay. And that's -- that's something that happened in 2003? All this -- is that an example that you're talking about?

A. What page was my Aetna example --

Q. Yes.

A. -- you're talking about?

Q. It's on 59. You say Premarin was switched to third tier in January of 2003.

A. That would have been the date, yes.

Q. Okay. And do you know at the time when Cenestin went on the marketplace how prevalent third tier was?

A. It was not as prevalent.

Q. All right. Do you know whether it was less than -- on the PBM side, if it was less than 25 percent?

A. Let's see. I have a --

Q. You've got an HMO example.

A. -- chart for that.

Q. You don't have a PBM example.
A. What I have in the way of objective data on that would have been in the -- in the graph that I cited.
Q. Right. And -- and you don't have a PBM example, so I'm asking whether you know what percentage of the marketplace on the PBM side was third tier during 1999, the year of the Cenestin launch.
A. In general, the PBM stats correlate with the HMO market.
Q. You're not aware of the fact that HMO went to third tier before most PBMs?
A. I'm aware that they did, but I'm saying roughly on any given, say, year to two-year cycle, they're -- they're quite similar.
Q. Okay. And -- and do you know, for example -- you would agree that the difference in the copayment, whether it's a -- I'm sorry.
You'd agree that the difference in going from a second to a third tier, the extent to which that matters to patients can vary depending upon the dollar amount of the -- of the copayment difference; right?

A. Correct.
Q. So if there's only a $5 difference from going from second to third tier, that can be different than a $15 difference; correct?
A. Correct.
Q. And --
A. Those numbers don't generally exist in the real world.
Q. Well, in 1999, do you know whether that -- whether copay differentials tended to be closer to $5 in difference or whether they were closer to 15?
A. The differentials between the copays for -- for the first tier, which would be generics, were usually around $5. The copays for second tier were usually somewhere between 10 and 15 dollars. Third tier may not be paid at all because they didn't exist.
Q. Okay. But in the three-tier -- in a three-tier formulary, in those situations, do you know in 1999 what the -- what the typical difference was?
A. The third tier in 1999 is cited on Page -- is demonstrated on Page 34, and it was a

very small portion of the market. The --
Q. Around 21 percent?
A. Well, the three-tier doesn't come through well in this -- in this reproduction of the slide, because it's different colors, but it looks to me that throughout the graph the commercial is the top bar and the --
Q. Meaning one tier?
A. No. There's three bars for each of the -- each of the segments --
Q. Okay.
A. -- you know, so that, for instance, on one tier you have four bars.
Q. Okay.
A. You see that?
Q. Yes.
A. Under the three-tier, it looks as thought either it was 2.7 percent or didn't exist for commercial.
MR. COHEN: Gordon, can I just show him a better copy?
MR. DOBIE: Yes, sure. I'm struggling for one myself.
MS. WARD: Jay, can I just ask a

clarifying question? Was it produced in color to us?
MR. COHEN: No, we didn't do a color copy. No.
A. But this -- this particular quality of this copy, it's clear what we've got here. We've got -- commercial is -- 2.7 percent of the commercial market in 1999 was three tier. And in Medicaid they had 18.9 percent.
BY MR. DOBIE:
Q. Okay.
A. Oh, I see. I see. Yes. Okay. Let me -- let me -- let me amend that.
It looks -- and I misread this. I was putting the 21.9 on the preferred-nonpreferred, and that's not correct. There's four bars in there.
Q. So the commercial is 21.9?
A. So it would be 21.9.
Q. No --
A. Medicaid would not exist. Medicare would be 2.7 and overall would be 18.9.
Q. 18.9 percent if you're on the HMO side.

Okay. What I was asking was whether you know in 1999 what the difference was in copay differentials between second and third tier.

A. And the second tier was just coming in, but it was usually double the copay amount for second tier.

Q. So you --

A. So it was 15, you would expect it to be around 30.

Q. Okay. And -- and we covered this yesterday, but I just want to make sure, now that we're doing it in the context of these documents, that I have your testimony and best -- best understanding to this.

It's your testimony that during this time period if Cenestin was placed on a third tier in this group of HMOs that it would have been reimbursed at -- or the -- strike that.

It's your belief that the patient would have paid the third-tier copay of $30 even if the cash price for that product at that time was $15?

A. I would -- what I -- what I -- what I discussed yesterday was I think that's a very

common practice.

Q. Okay. And that's --

A. Whether people will admit to it or not is questionable. But that was a fairly common practice.

Q. Okay. And that's -- and you reached that conclusion without having the benefit of the Duramed documents that I showed you this morning; correct?

A. Correct.

Q. Okay. Let me -- let me just follow up on this then in terms of that being a common practice.

In those situations where that happens and the -- and the patient is charged the $30 copay as opposed to the $15 cash price for Cenestin, who gets the $30?

A. The pharmacy.

Q. Okay. So in the case of CVS and Rite Aid, for example, they were doing that here in 1999, they were charging patients $30 for Cenestin as opposed to the $15 cash price, they would have profited from that?

A. They would. The practice -- the

predominance of that type of behavior is more common in the independent pharmacies than the chains and it's more common in the mail orders.

Q. And have you ever --

A. And the mail orders are more common with generics.

Q. Okay. And have you ever had any discussions with anybody that is a plaintiff in this case in terms of -- and that's an independent pharmacy, J.B.D.L., in terms of what they were doing? Were they charging the cash price --

A. No, I did not.

Q. Let him finish the question.

-- the cash price or the -- or the copay?

A. No.

* * *

(Whereupon, Gibson Exhibit 23 was marked for identification.)

* * *

BY MR. DOBIE:

Q. We've handed you Exhibit 24.

A. No. This is an authoritative article.

MR. DOBIE: 22?

MS. WARD: 23.

MR. COHEN: David, she needs that back.

THE WITNESS: Oh. Sorry.

BY MR. DOBIE:

Q. It's Exhibit 23, and as you mentioned, this is an article that you wrote having to do with whether we were spending too much on pharmaceutical products; right?

A. Correct.

Q. And generally speaking, your sort of macroeconomic view is that -- is that America should be spending more for pharmaceutical products?

A. My general macro view is that Americans should be taking more pharmaceutical products. Whether they should be spending more or not is another issue.

Q. All right. Well, that's what your headline says; right?

A. Right. But that's -- what the core of the article is that half the drugs prescribed are not filled.

Q. And I want to ask you about -- on the very first page, there's a discussion about HMOs having erected costly and uniformly inexpensive -- ineffective cost containment strategies?
A. Yes.
Q. And you note that HMOs' prior authorization requirements represent an expensive and labor intensive -- to manage; right?
A. Correct.
Q. And you say that "Many plans quote costs of $10 to $25 per prior authorization request, with more than 80 percent of the requests being approved"; right?
A. Right.
Q. So do I have it right that first -- in the first instance, your -- your understanding is that most times when a -- when a patient or a physician seek prior authorization, it's approved in 80 percent of the -- 80 percent of the cases?
A. Yes. It may not be approved right away, but if you look back on all the denials within a managed care environment, six months later 80 percent will have either been authorized

at the time of request or within a six-month period.
Q. Right. And -- okay. So you go on to say then that "Upon review at six months, the approval rate approaches 100 percent."
A. Yes.
Q. So -- so your experience is that generally managed care companies at the end of the day approve prior authorization requests?
A. Generally.
Q. And were you aware, sir, that Cenestin reject -- I'm sorry, that Duramed rejected the strategy of asking -- or seeking to have physicians complete prior authorization forms for the product?
A. Say that again.
Q. Were you aware that Duramed decided not to -- not to have its sales force seek prior authorizations for its products?
A. Duramed doesn't have prior authorization requests. That would be the PBM.
Q. Okay. Do you know whether or not it was ever recommendeded to them that they have forms in their sales force materials when they

went out to customers that they could present to customers to seek prior authorization for the approval of Cenestin prescriptions in those instances where a patient had Cenestin on a formulary that was -- that was either in the third tier or in a nonapproved position?
A. I have no knowledge of that. I'd find it unusual, because the prior authorization forms are different for the different PBMs and they are not generated by the pharmaceutical manufacturer. You may find that they issued a series of talking points or something to fill in under the request. I don't know.
Q. Okay. Is it true, sir, that with -- that most prior authorization requests do cost 10 to 25 dollars?
A. Now, understand what we're talking about in -- in this article. I'm talking about medical management, not pharmacy management.
Q. Who is -- who is the 10 to 25 dollars in cost?
A. This is medical management.
Q. Okay. And medical management refers to what entity?

A. That would be the HMO with its infrastructure of medical management that consumes somewhere between 5 and 6 percent of premium.
Q. Okay. So in the instance of like a -- so this would be like an Aetna?
A. Be like an Aetna or a -- or a United or a HealthNet.
Q. Okay. And does the fact that it would cost 10 or 25 dollars to do a prior authorization for a product -- is that -- does that -- is that consistent with the fact that a group like Aetna might decide not to bother with prior authorizations for an inexpensive product, pharmaceutical product generally?
A. It might. It's -- if you want my opinion, I'll give it at the risk of sounding like an advocate.
Q. Well, I've shown you this morning Exhibit 18, where Aetna is -- according to Duramed, is going to allow the prescriptions to be filled at the same copay level as the formulary products. And -- and I'm wondering if the fact that it would cost 10 to 25 dollars per prior authorization request, whether that might be a

reason why somebody like Aetna might decide to just allow Cenestin prescriptions to be filled at the same copay level as Premarin rather than have its members go through -- or patients go through prior authorization requests.

A. You are mixing apples and oranges. The price quoted here is medical management cost, which is not automated. The prior authorization in a PBM setting is much more an automated process handled at a lower level. It only bounces up to senior management if it's denied.

Q. Okay. I'm talking Aetna, though, as an example. That is an HMO; right?

A. It is an HMO, but I -- I'm not certain whether they have their own internal PBM or they instructed their PBM to administer it in the fashion that they did. But I'm just saying that the cost per prior authorization to process in medical management is considerably greater than the prior authorization process for a PBM.

Q. Okay. Well, you mentioned United. That's a -- that is an HMO; right?

A. Correct.

Q. Okay. And United if -- again

looking --

A. Where did I mentioned that in --

Q. No. You mentioned it in response to my question a moment ago --

A. Oh, I see.

Q. -- another HMO. Okay. At United, they say that although Cenestin is considered nonformulary, however it's being reimbursed in the majority of their plans to the $13 copay level. And again I'm just wondering, is the fact that it would cost 10 to 25 dollars per prior authorization request for a group like United Healthcare, whether that might be a reason why they would simply allow the prescription to go through at the same copay level.

A. To answer that, I'd have to speculate. I --

Q. You don't know?

A. It's reasonable, but I don't know.

Q. Okay. Generally speaking, would you agree that prior authorizations are more often used with expensive products as opposed to inexpensive products?

A. Generally. There were very

interesting examples in Wyeth's own documents where they placed the requirement for prior authorization for Cenestin as one of their contracting points.

Q. Okay.

A. That would -- that certainly caught my eye.

Q. Which -- where did you find that there was a requirement for there to be a prior authorization?

A. On Page 67 and 68.

Q. Okay. And the example that you cite is MedImpact?

A. Wellpoint.

Q. I'm sorry.

A. Page 67 and 68 under "NDC blocks," Item 7.

Q. And it's your testimony that Wyeth required them to put NDC blocks in place at Wellpoint?

A. I haven't testified to it yet. I am --I am pointing out an example where a contract -- a document from Wyeth which was the reimbursement agreement with Wellpoint stipulated

that a NDC block be in place and to overcome an NDC block in general in the industry requires a prior authorization.

* * *

(Whereupon, Gibson Exhibit 24 was marked for identification.)

* * *

BY MR. DOBIE:

Q. Okay. Let me show you what we've marked as Exhibit 24. This is the document that you've cited in your report.

A. This is -- this is Wyeth 23418. Okay.

Q. This is an amendment that's an agreement between Wellpoint and Wyeth that you referenced; correct?

A. Correct.

Q. And if you look on the first page, this is the language of the contract that you're referring to; right?

A. Correct.

Q. And, in fact, it doesn't say that they're required to put in NDC blocks. It says that "Wellpoint shall use reasonable efforts to

ensure the use of Wyeth-Ayerst HRT products and discourage the use of of nonformulary products through appropriate means that may include the use of NDC blocks and/or differential copays where the benefit design allows." Do you see that?

A. I do.

Q. Okay. So they weren't required to use NDC blocks. They had a choice of using NDC blocks, differential copays, and only where the benefit design allowed; right?

A. Correct.

Q. And -- and this related to -- this actually related to -- not to Premarin but to Prempro and Premphase, right, not Premarin?

A. Correct.

Q. Okay. And so do you have any other examples where a -- any sort of plan was, quote, required to put NDC blocks in place?

A. If you'll give me --

Q. Sure.

A. -- just a minute here, I'd like -- I'd like to go through my report.

MR. COHEN: I just want to insert a late objection to the form of that question.

The report doesn't say "required." It says "may be required."

MR. DOBIE: I was responding to his testimony.

MR. COHEN: While we're waiting, Gordon, how are we looking on time because it's approaching 1 o'clock.

MR. DOBIE: I know. Let's -- let's keep going. We're not doing bad.

MR. COHEN: Any estimate? Because he's got a flight to catch.

MR. DOBIE: I know.

A. I do not have -- what I was -- what I was looking for was exhibit on Page 57, which indicates the percentage of the market that requires prior authorization for each of the products. This an internal document from Wyeth. See that?

BY MR. DOBIE:

Q. I do. Did you interpret this as this is the percentage of the marketplace that has prior authorization for Cenestin?

A. Yes.

Q. Okay. Have you ever used Scott Levin data before?

A. I've seen and used it in other instances. I don't recall exactly where.

Q. Do you --

A. It's a respected name.

Q. Okay. Do you know that -- do you have any reason to dispute the fact that what this is referring to by "prior authorization" with these percentages is of those plans that actually put prior authorization in for Cenestin or other products in this category, those that -- strike that.

Are you aware of the fact that what the Scott Levin data is referring to is that of -- for those HMOs that that use prior authorization for either the ERT or HRT class that that's the percentage that would -- would have applied it to -- whether it's Ativella, Cenestin, FemHRT, or the others?

MR. COHEN: Object to the form.

A. That's not the way I interpreted --

BY MR. DOBIE:

Q. Okay. You --

A. -- the report.

Q. You believe that in the fall of 2001 50 percent or 49 percent of the market had prior authorization in place for Cenestin?

A. That's the way I interpreted the chart.

Q. Okay. Have you ever had any discussions with anyone to try to get behind those -- those numbers and understand what that means?

A. I know that if you are not on the second tier, it's not unusual to selectively have prior authorization on other products either for cost or for the opportunity to influence decision making and drug selection.

Q. Okay. So is it your belief, knowing as you -- you've written an article on this, that prior authorizations would cost 10 to 25 dollars every time you get it, that 50 percent of the market in the fall of 2001 was doing a prior authorization for Cenestin?

A. First of all, we've been over this. It isn't 10 to 25 dollars for -- for a PBM to do a prior authorization. It is -- so that first part of that question, we -- to break up the apples and

oranges.

The thing that's very interesting to me about prior authorizations is the way the industry is bifurcating between PBMs and medical managers. The PBMs are keeping in place the tools like prior authorization when the rest of the industry is moving away from it because it's not effective. What I infer from that is that it's now used more in the industry to steer market share than to -- for any other purpose.

Q. Okay. But sir, the data that you have in this chart on Page 57, that's from a Wyeth document; right?

A. Yes. It's referenced.

Q. Okay. And -- and this prior authorization relates only to HMOs; correct?

A. Percentage of HMO lives, that's correct.

Q. Okay. And so for HMOs, it would cost 10 or 25 dollars to do a prior authorization, according to your article, for Cenestin; right?

A. I'm having trouble getting this across.

An HMO -- many of them outsource the

management of their pharmacy benefit to a PBM. If they have a captive internally like Pacificare did, they would flip that prior authorization into the norms for the PBM industry.

Q. Okay. Do you know whether or not the prior authorization figures that are located here are based upon every HMO in the industry as opposed to, let's say, fewer than 10?

A. Let's see. What page are you on now?

Q. I'm looking at your Page 57.

A. 57. It is my understanding that this was normative data for the industry and it was not footnoted as being as being -- as being -- tracking a particular group of companies.

Q. Okay. So -- but as you're presenting it here in the report, do you mean -- I mean, do you mean to be telling the jury that it's your belief that 49 percent of HMOs had prior authorization in place for Cenestin in the fall of 2001?

A. Correct.

Q. Okay. And in deciding to do that, you don't know whether or not that's 10 HMOs that

is included within this group or a hundred; right?

A. Right. I don't have the methodology behind their obtaining the data and the normative data.

Q. And you don't know whether or not this refers to all of the HMOs that were -- were pulled or only those HMOs that had prior authorizations in place for this class of products; right?

A. As I read this document, which is cited in the report, I did not recall those qualifiers being in place. If they were, I would have cited it or I would have included it in the report.

Q. How about on the NDC block side? You -- I had asked you a question, we sort of got distracted, about whether or not you were familiar with any situation in the marketplace where there was an NDC block in place for Cenestin. And we talked about the Wellpoint contract. Anything else that you're -- that you're familiar with?

A. That -- the section of the report that I pulled that from is what I -- comes to mind right now. I know that the Premarin preemptive

plan called for attempting to put those into place. I don't recall if the contracting manual included that. I believe I remember it did. But being able to cite for you contract examples --

Q. I guess I'm wondering is, are you aware of whether or not NDC blocks were, in fact, put in place at any PBM or HMO?

MR. COHEN: With respect to Cenestin?

MR. DOBIE: Yes, sir.

A. I'm having trouble finding it now, but there was -- there -- I cited examples where the PBMs would try to come up with ways to enhance their performance rebates, and I -- as I recall, they discussed using techniques like blocks. I don't recall that there was a link to it being a contractual requirement.

BY MR. DOBIE:

Q. There's a -- if you turn, sir, to -- and so the answer is you're not familiar with -- with whether it actually -- NDC blocks were, in fact, put in place as it relates to Cenestin?

A. I'm saying that I cannot testify now and cite to you an example of it.

Q. All right. You mentioned in Page 42 of your report -- you have discussion of the Medicaid rebate program, and I want to make sure I understand the significance of that.

It's your testimony, as I understand, sir, that -- that Wyeth could not offer greater than a 15 percent rebate because of Medicaid rules?

A. Correct. I was discussing specifically the Omnibus Budget Reconciliation Act and its requirements.

Q. Okay. And --

A. And it's -- that's an important upper limit that they can't butt into without changing their -- their structures with Medicaid.

* * *

(Whereupon, Gibson Exhibit 25 was marked for identification.)

* * *

BY MR. DOBIE:

Q. All right. And let me hand you Exhibit 855 -- this is now Exhibit 25. This is a document from Wyeth. It's the pricing and contracting strategy as of April 20 -- April 2001.

Have you ever seen this document before, sir?

A. No.

Q. All right. If you look at the second page of the document, there's a heading that says "Government Strategy."

A. Yes.

Q. And under "Medicaid," it's sort of in the middle of the page, there's a discussion of the discount from AMP and you see that the discount is, in fact, 64 percent, 62 percent, and as much as 65 percent depending on the particular Premarin strength?

A. Yes.

Q. All right. But you weren't aware that Wyeth discounted to that extent on the Medicaid side of the business?

A. What I was referring to in -- where we started this was that there's an upper limit to how far you can discount in general on commercial side, that -- that there is no limit to where you can go on government contracts.

Q. Right. So to the extent that Wyeth has made these significant discounts on the government side, on Medicaid, it could actually

have larger than 15 percent discounts on the commercial side; correct?

A. It could if it had similar numbers for all their government contracts.

Q. All right. And do you have any reason to think that they didn't have similar numbers for their other federal government contracts?

A. I have no basis to give an opinion on that.

Q. Okay.

A. This is the first time I've seen this.

Q. Understood. And, in fact, if you'd look at the top of that same page, you could see that Wyeth did offer 25 percent performance rebates to Harvard, CIGNA, and Humana; correct?

A. That's what it indicates here, yes.

Q. All right. And you weren't aware of that before?

A. I was not aware that it was that great.

Q. And by the same token, at the top of the page, you see that there are existing

contracts with PBMs that have discounts up to 22 percent; right?

A. Again, it gets us back into our discussion which we enjoyed so much yesterday of how you define your rebates and what goes into them. Rebates can be defined as rebates off of the actual product acquisition or the product dispensing transaction or they can be administrative fees which can help you get around the 15 percent and they can be involving the mail order.

Q. Okay. But your report, sir, says that the size of the rebate can range up to 15 percent of the direct -- the DCP price; right? "Rebates greater than 15 percent are rare, since they might cause manufacturers to exceed their 'Medicaid best price' rebates and trigger repricing of government contracts."

Now that you've seen Exhibit 25, do you think that that's applicable as it relates to Premarin during this time period?

A. Once again, we don't -- I don't have enough data to render an opinion here. I will tell you that the 15 percent number that I put in

here and footnoted is consistent with the general industry's approach to rebates and I am not quite certain how they calculated these percentages.

Q. Do you know whether Duramed has offered rebates in the -- either on the Medicaid or MediCal -- state Medicaid level formularies that exceed 15 percent?

A. I'm -- I'm not aware -- I'm not knowledgeable of it.

Q. Do you know whether or not Duramed has offered or Barr Labs has offered rebates that exceed 15 percent for Cenestin?

A. In the commercial market --

Q. Yes, sir.

A. -- or the Medicare?

Q. Yes, sir.

A. I think the -- it would be unusual for them to without bringing it in tangentially, as I mentioned with other -- in other buckets.

Q. So -- but assuming that they offered the government rebates that were of equal size, if not significantly greater, then they certainly would be in a position to offer the commercial market greater rebates; right?

A. Again, assuming that they offered these levels of rebates throughout their government, both federal and state, contracts, yes. We don't know that from this document.

Q. And you haven't seen the Duramed documents relating to their rebate agreements with MediCal, for example?

A. No.

Q. And their rebate agreements with any other state?

A. Correct.

Q. And you haven't reviewed the Duramed contracts or the Barr contracts as it relates to the size of the rebates that they've actually offered other managed care organizations?

A. Those are generally proprietary and not available for inspection by disinterested third parties.

Q. Okay. Well, as an expert witness in this case, you haven't asked your counsel to review the Duramed or Barr agreements as it relates to the size of the rebates --

A. That's correct.

Q. -- that they're offering.

MR. DOBIE: Let's -- let's take a two-minute break.

THE VIDEOGRAPHER: We're going off the record. The time is 1:15 p.m.

This is the end of Tape No. 2. The time is 1:16 p.m. We're off the record.

* * *

(Whereupon, a short recess was taken.)

* * *

THE VIDEOGRAPHER: This is the beginning of Tape No. 3. The time is 1:25 p.m. We're back on the record.

BY MR. DOBIE:

Q. Dr. Gibson, just a few things to clarify.

First, you have not quantified the extent to which NDC blocks were, in fact, employed against Cenestin; correct?

A. That's correct.

Q. And you have not quantified the extent to which prior authorizations were put in effect against Cenestin; correct?

A. Based on contracts.

Q. Based upon -- in the marketplace.

A. Well, this -- this graph that we were discussing just before the break --

Q. Other than that chart that we were talking about before the break, you have not in any way quantified the amount or frequency of prior authorizations that Cenestin may have faced in the marketplace; correct?

A. Correct.

Q. And that is really the sole basis for your belief that Cenestin faced prior authorizations in any significant extent; correct?

A. Correct.

Q. And did you do any study to determine whether or not it was more common that physicians were not writing Cenestin prescriptions because of problems with the product, lack of indications, lack of a clinical history, things like that, versus formulary placement?

A. I will give you an opinion. I don't have a study that I did. Are you asking me if I did a study?

Q. Yes, did you do a study?

A. I didn't do a study.

Q. Okay. And in order to know -- in order to really know for certain whether or not physicians were not writing Cenestin because of problems with the product versus formulary placement, you would have to do such a study; right?

A. It's late in the day. You have to understand all that I've said up to this point about Cenestin being a niche player, not a replacement product.

Q. Understood.

A. I believe that the hassle factor for a physician to try a new drug in a niche market would have been substantial with the enforcement mechanisms of the formulary, including NDC blocks and prior authorizations.

Q. Okay. I guess what I'm trying to understand is, it's your opinion that they would have been, but you have not actually quantified or determined whether or not, in fact, that's the reason why physicians weren't writing the prescriptions?

A. I did cite instances from the documents where physicians tried the drug,

Cenestin, and met this enforcement mechanism and indicated they would stop trying to use the drug.

Q. But even in those 12 instances, as we discussed before, you don't even know whether or not Premarin was even on formulary or whether or not the particular plan had a contract with Wyeth at all or whether the product was simply rejected because the plan decided that they did not like Cenestin; right?

A. Correct.

Q. Okay. Let me just ask you a couple of followups here.

A. That was mixing apples and oranges on that -- why that was in the report. That was in the report to illustrate the effectiveness of the enforcement mechanism that backs a formulary.

Q. Do you -- do you know whether or not any of these enforcement mechanisms were ever used with Cenestin at PCN?

A. I don't. I know that -- I know that if Cenestin were not on the second tier, it would face a higher copayment. I don't believe that it has gone beyond that at PCN, but I can't testify that for sure.

Q. Do you know, in the period before it went on the third tier for three-tier formularies at PCN, whether Cenestin prescriptions just sailed through and were reimbursed just like Premarin?

A. It would depend on the client and how they set up the terms for the third tier.

Q. Okay. And -- and I guess what I'm asking, do you know how it was handled within PCN client plans before Cenestin was added to the third tier?

A. I know generally.

Q. And what is your understanding of how it was handled?

A. Generally the -- PCN would present to the client a tiered structure that had increasing copayment amounts, and if there was not a third tier, it would generally not have been paid for.

Q. And in those instances -- so it's your belief that at PCN the Cenestin prescriptions would have been not reimbursed in the time period before it went on third tier?

A. That would be my bet. I haven't checked it, but that would be my likely bet.

Q. All right. But you don't know?

A. I don't know.

Q. And since it's gone on third tier, is it your expectation that most plans have put Cenestin on third tier?

A. Yes. That's the reason the whole third tier came into existence. There was a huge backlash in the market against the restrictiveness of just two-tier plans.

Q. Right.

A. So the third tier came in to respond to that market demand and now just about everything is on the third tier.

Q. And do you know whether or not Cenestin is reimbursed at the third-tier level or whether it's reimbursed at second tier just by being on the third tier?

A. I don't.

Q. You mentioned -- you mentioned I think a little bit earlier about the significance in your view of the -- of the launch period, the time of the product.

A. Yes, I did.

Q. Do you think that there's a

difference from what you've seen between Cenestin's success -- strike that.

Is there a difference in your view between how -- how many -- how many plans Cenestin was on in, let's say, 2002 versus 1999?

A. How many plans Cenestin was on where?

Q. It's a poorly phrased question.

Is -- is it your belief that these things you're talking about that would be a disadvantage to Cenestin -- is it your -- is it your view that those things were happening more in 1999 or 2002 or do you think it was all about the same?

A. I think it was much more evident earlier. That was part of that movement in the market to less restrictive products. It was back during the time when Cenestin was being introduced that the formulary was much more restrictive than it is today.

Q. And that's -- that's true not just as it relates to Cenestin, but generally now, I think as you've indicated, formularies are more open than they were in 1999?

A. That's correct.

* * *

(Whereupon, Gibson Exhibit 26 was marked for identification.)

* * *

BY MR. DOBIE:

Q. Let me show you what's been marked as Exhibit 26. This is a copy of the subpoena, Dr. Gibson, that you received in this case to produce documents. And we haven't received any documents. Does that mean you don't have any of the documents that are requested in the subpoena?

A. I have -- I have none of the documents and I have no custody of the documents and if I did, I'd have no authority to release them.

Q. Okay. So you don't even have a copy of the PCN formulary or preferred drug list? You don't keep one of those?

A. I pulled down the same copy that you got off the Net.

Q. Okay. And -- and as medical director, you don't have any authority in your view to provide any of these documents?

A. That would generally be an officer of the company. I'm not an officer of the company.

Q. Have you had discussions with anybody at PCN about the subpoena that we served on Mr. Scull to obtain PCN's documents?

A. After I got the subpoena, I called Mr. Scull and I told him that I had received this and I sent him a copy of it and I requested that he take responsibility for it, in that it was documents dealing with PCN, and it was my understanding that he did and that he referred the matter to PCN's law firm, which was something or other and Pillsbury out in San Francisco, and that I got a phone call from the lawyer -- I believe her name was Maureen -- who was with the firm and that she was having conversations both with you and with -- with Mr. Cohen. So that's pretty much the extent of what I know about this.

Q. Did you discuss with her the -- let me -- let me sort of back up.

How many discussions did you have with Mr. Scull about the subpoenas?

A. One.

Q. And how many discussions did you have with the lawyer at Pillsbury?

A. One.

Q. All right. And do you know whether or not there's addtional documents that -- that PCN is producing in response to this subpoena?

A. I don't know. I heard while I've been here that you'd had conversations with the law firm and that there were more -- you were expecting more documents, but that's the first I'd heard of that.

Q. Okay. Did you -- at any time in your discussions with anybody involved in this in connection with PCN, have you requested that any documents be withheld from this litigation?

A. No.

Q. And do I take it you don't have any objection at least to these documents being produced?

A. No, not at all.

MR. DOBIE: Sir, I appreciate your patience with this. I don't have any other questions for you at this time and I hope you make your flight.

THE WITNESS: Thank you.
MR. DOBIE: Thank you very much.
THE WITNESS: I wish I could say I enjoyed the experience, but I enjoyed getting to know you.
THE VIDEOGRAPHER: This concludes the videotape deposition of David Gibson. The time is 1:37 p.m. We're now off the record.

* * *

(Whereupon, the deposition concluded at 1:37 p.m.)

* * *

INSTRUCTIONS TO WITNESS

Please read your deposition over carefully and make any necessary corrections. You should state the reason in the appropriate space on the errata sheet for any corrections that are made.

After doing so, please sign the errata sheet and date it.

You are signing same subject to the corrections you have noted on the errata sheet, which will be attached to your deposition.

It is imperative that you return the original errata sheet to the deposing attorney within thirty (30) days of receipt of the deposition transcript by you. If you fail to do so, the deposition transcript may be deemed to be accurate and may be used in court.

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E R R A T A

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ACKNOWLEDGMENT OF DEPONENT

I, _____, do hereby certify that I have read the foregoing pages, _____, and that the same is a correct transcription of the answers given by me to the questions herein propounded, except for the corrections or changes in form or substance, if any, noted in the attached Errata Sheet.

_____
DATE

Subscribed and sworn to before me this

_____ day of _____,
200_.

My commission expires: _____

_____
Notary Public

C E R T I F I C A T E

I hereby certify that the witness was duly sworn by me and that the deposition is a true; record of the testimony given by the witness.

It was requested before completion of the deposition that the witness, DAVID J. GIBSON, M.D., have the opportunity to read and sign the deposition transcript.

_____

McKINLEY WISE, CM

Dated: May 28, 2004

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LAWYER'S NOTES

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